

10917

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>27 Shaw Street</u>		d. STREET ADDRESS <u>27 Shaw Street</u>	
3. NAME OF DECEASED (Type or print) <u>Earnest Anderson</u>		4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-4-1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>19</u> Hours <u>59</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert Anderson</u>		14. MOTHER'S M maiden NAME <u>Victoria Queen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-0886</u>	
17. INFORMANT <u>Eliza Jones Crononville Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (c) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/12/59</u> to <u>10/23/59</u> , that I last saw the deceased alive on <u>10/23/59</u> , and that death occurred at <u>10/23/59</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. P. Beckwith</u>		ADDRESS (Street, city or town, state) <u>110-6474 ST ANNAPOLIS MD.</u> DATE SIGNED <u>10/23/59</u>	
PHYSICIAN'S NAME (Type) <u>William Reese #108 Wash St. Annapolis</u>		M.D. <u>110-6474 ST ANNAPOLIS MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Sabor</u>	22d. LOCATION (City, town, or county) (State) <u>Chesterfield Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese #108 Wash St. Annapolis</u>		ADDRESS <u>110-6474 ST ANNAPOLIS MD.</u>	
24. REC'D BY REGISTRAR <u>29 59</u>		25. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

The first part of the paper is devoted to a discussion of the  
 various methods of determining the rate of reaction. The  
 most common method is the use of a clock reaction, in which  
 the reaction is allowed to proceed for a certain time and then  
 stopped by the addition of a reagent which causes a color  
 change. The time taken for the color change to occur is  
 measured and the rate of reaction is calculated from this  
 time. Another method is the use of a titration, in which the  
 reaction is allowed to proceed for a certain time and then  
 stopped by the addition of a reagent which causes a color  
 change. The volume of reagent required to cause the color  
 change is measured and the rate of reaction is calculated from  
 this volume. A third method is the use of a spectrophotometer,  
 in which the reaction is allowed to proceed for a certain time  
 and then the absorbance of the solution is measured. The  
 absorbance is proportional to the concentration of the  
 reactants and the rate of reaction is calculated from this  
 absorbance.

The second part of the paper is devoted to a discussion of the  
 various factors which affect the rate of reaction. The most  
 important factors are the concentration of the reactants, the  
 temperature, and the presence of a catalyst. The rate of  
 reaction increases with increasing concentration of the  
 reactants, with increasing temperature, and with the presence  
 of a catalyst.

The third part of the paper is devoted to a discussion of the  
 various theories of reaction rates. The most common theory is  
 the collision theory, which states that the rate of reaction is  
 proportional to the number of collisions between the reactant  
 molecules. Another theory is the transition state theory, which  
 states that the rate of reaction is proportional to the number  
 of molecules which have enough energy to overcome the energy  
 barrier of the reaction.

The fourth part of the paper is devoted to a discussion of the  
 various applications of reaction rates. The most common  
 application is in the study of chemical kinetics, in which the  
 rate of reaction is used to determine the mechanism of the  
 reaction. Another application is in the study of chemical  
 equilibrium, in which the rate of reaction is used to determine  
 the position of the equilibrium.

10958

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CL. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CL. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arundel Gardens</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>522 Holy Cross Rd.</u>		d. STREET ADDRESS <u>522 Holy Cross Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>L</u> Last <u>Baer</u>		4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 7 - 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>US.</u>	
13. FATHER'S NAME <u>Jacob De Beer</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>Mr. Char. W. Baer</u> Address <u>36 N. Dudley Ave. (13)</u>	
17. INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>447X Hypertensive Vascular Disease</u> DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November, 1955</u> to <u>Oct 13, 1959</u> that I last saw the deceased alive on <u>Oct 13, 1959</u> , and that death occurred at <u>9:30 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Florian P Nadolski</u> M.D.		ADDRESS (Street, city or town, state) <u>2703 Hammond Perry Rd Baltimore</u> DATE SIGNED <u>Oct 16, 59</u>	
PHYSICIAN'S NAME (Type) <u>Florian P Nadolski</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>10/19/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>3801 Fred Ave.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard Low</u> ADDRESS <u>901 Hollen St</u>		24a. REC'D BY REGISTRAR <u>Anthony S. Frank</u> 24b. REGISTRAR'S SIGNATURE	
DATE <u>OCT 19 59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 40

DECEASED  
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DATE OF DEATH  
PLACE OF BIRTH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
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PREVIOUS ILLNESS  
PREVIOUS SURGERY  
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PREVIOUS ALCOHOL  
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## CERTIFICATE OF DEATH

Reg. Dist. No.

10918

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Paul</b> Last <b>BEALL</b>		4. DATE OF DEATH Month <b>October</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1882</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew R. Paul</b>		14. MOTHER'S MAIDEN NAME <b>Adeline Patch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Informant Mrs. Ollie M. Beall #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>hypertricular failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerotic cardiovascular disease</b> DUE TO <b>10 yrs.</b> (c) <b>10 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>59</b> , to <b>Oct</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct 17</b> , 19 <b>59</b> , and that death occurred at <b>11:48 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>121 Cathedral St., Annapolis, Md.</b> DATE SIGNED <b>10/19/59</b>			
ACTUAL SIGNATURE <b>John H. Hedeman</b>		M.D. <b>121 Cathedral St., Annapolis, Md.</b>	
PHYSICIAN'S NAME (Type) <b>John Hedeman</b>		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 22 - 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Des Moines Iowa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Taylor &amp; Sons Annapolis, Md.</b>		ADDRESS <b>Annapolis, Md.</b>	
24a. REC'D BY REGISTRAR <b>OCT 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10959

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>A.A. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverside Beach</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverside Beach</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>257 Crundel Rd.</i>		d. STREET ADDRESS <i>257 Crundel Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>DEWEY</i> First <i>H.</i> Middle <i>BECKHAM</i> Last		4. DATE OF DEATH Month <i>OCT.</i> Day <i>25</i> Year <i>1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-8-16</i>
9. AGE (In years last birthday) <i>43</i> yrs.		IF UNDER 1 YEAR: Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Contractor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>	
11. BIRTHPLACE (State or foreign country) <i>N.C.</i>		12. CITIZEN OF WHAT COUNTRY <i></i>	
13. FATHER'S NAME <i>Oscar W.</i>		14. MOTHER'S MAIDEN NAME <i>Laura Hunter</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>579-M-1667</i>	
17. INFORMANT <i>Family</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MYOCARDIAL FAILURE</i> <i>241 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>STATUS ASTHMATICUS</i> DUE TO (c) <i>BRONCHIAL ASTHMA</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12 HRS</i> <i>24 HRS</i> <i>43 YRS</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>CACHEXIA</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i></i> a. m. <i>19</i> p. m. <i></i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct 22</i> , 1959, to <i>Oct 24</i> , 1959, that I last saw the deceased alive on <i>Oct 24</i> , 1959, and that death occurred at <i>6 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arthur Lankford Jr.</i>		ADDRESS (Street, city or town, state) <i>M.D. Mountain Rd.</i> DATE SIGNED <i>10-25-59</i>	
PHYSICIAN'S NAME (Type) <i>ARTHUR LANKFORD JR. MD.</i> <i>Pasadena, Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>10-28-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Flower Garden</i>	22d. LOCATION (City, town, or county) (State) <i>Flower Garden Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. Cully</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 27 '59</i>	
ADDRESS <i>Funeral Home 120th 30th</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2022

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

**DECEASED**  
Name: *John Doe*  
Date of Birth: *10/15/1945*  
Date of Death: *11/10/2022*  
Place of Death: *Home*  
Cause of Death: *Heart Disease*  
Certified by: *Dr. John Smith*  
Signature: *[Signature]*  
Date: *11/15/2022*

10960

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN lb <u>3 years 8mo. 12 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wilbur</u> Middle Last <u>Bell</u>				4. DATE OF DEATH Month <u>10</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1904</u>		9. AGE (In years last birthday) <u>55</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Bell</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Bantt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> DUE TO <u>Cancer of Penis</u> (b) <u>With Metastasis in the Bladder</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome with Alcoholism</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. --- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/16</u> , 19 <u>56</u> , to <u>10/28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/28</u> , 19 <u>59</u> , and that death occurred at <u>2:10 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>10/28/59</u>							
ACTUAL SIGNATURE <u>L. Benedict, M. D.</u>		M.D. <u>Crownsville State Hospital, Md.</u> <u>10/28/59</u>					
PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>		Crownsville State Hospital, Md. <u>10/28/59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Oct 31 1959</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Bell</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis</u> <u>Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Johnson</u> ADDRESS <u>Annapolis</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10961

## CERTIFICATE OF DEATH

## 10907

Reg. Dist. No.

<b>1 PLACE OF DEATH</b> a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>1 year 3mo. 1 day</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>Unknown</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>William Harrison Best</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>10 24 19 59</u>				
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>1870?</u>		<b>9. AGE</b> (In years last birthday) <u>89?</u> yrs		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-----</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Georgia</u>		
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			<b>13. FATHER'S NAME</b> <u>John Best</u>				
<b>14. MOTHER'S MAIDEN NAME</b> <u>Matilda Jackson</u>			<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				
<b>16. SOCIAL SECURITY NO</b> <u>Unknown</u>			<b>17. INFORMANT</b> <u>Hospital Records</u>				
<b>18 CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> (b) <u>Chronic Brain Syndrome Associated with Arteriosclerosis with Psychosis</u> (c) <u>since admission</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Diabetes mellitus</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <u>-----</u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>-----</u>			
<b>20f. (City or town)</b> <u>-----</u>		<b>20g. (County)</b> <u>-----</u>		<b>20h. (State)</b> <u>-----</u>			
<b>21. I certify that I attended the deceased from</b> <u>7/23</u> , 19 <u>58</u> , to <u>10/24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/24</u> , 19 <u>59</u> , and that death occurred at <u>12:10</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>10/26/59</u>							
<b>ACTUAL SIGNATURE</b> <u>[Signature]</u> M.D.							
<b>PHYSICIAN'S NAME (Type)</b> <u>L. Benedict, M. D.</u> <u>Crownsville State Hospital, Md.</u> <u>10/26/59</u>							
<b>22a. BURIAL, CREMATION, OR REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>10-29-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Calvary Cem.</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>A.A. County, Md.</u>		<b>22e. REGISTERAR'S SIGNATURE</b> <u>[Signature]</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u>		<b>24a. REC'D BY REGISTRAR</b> <u>[Signature]</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
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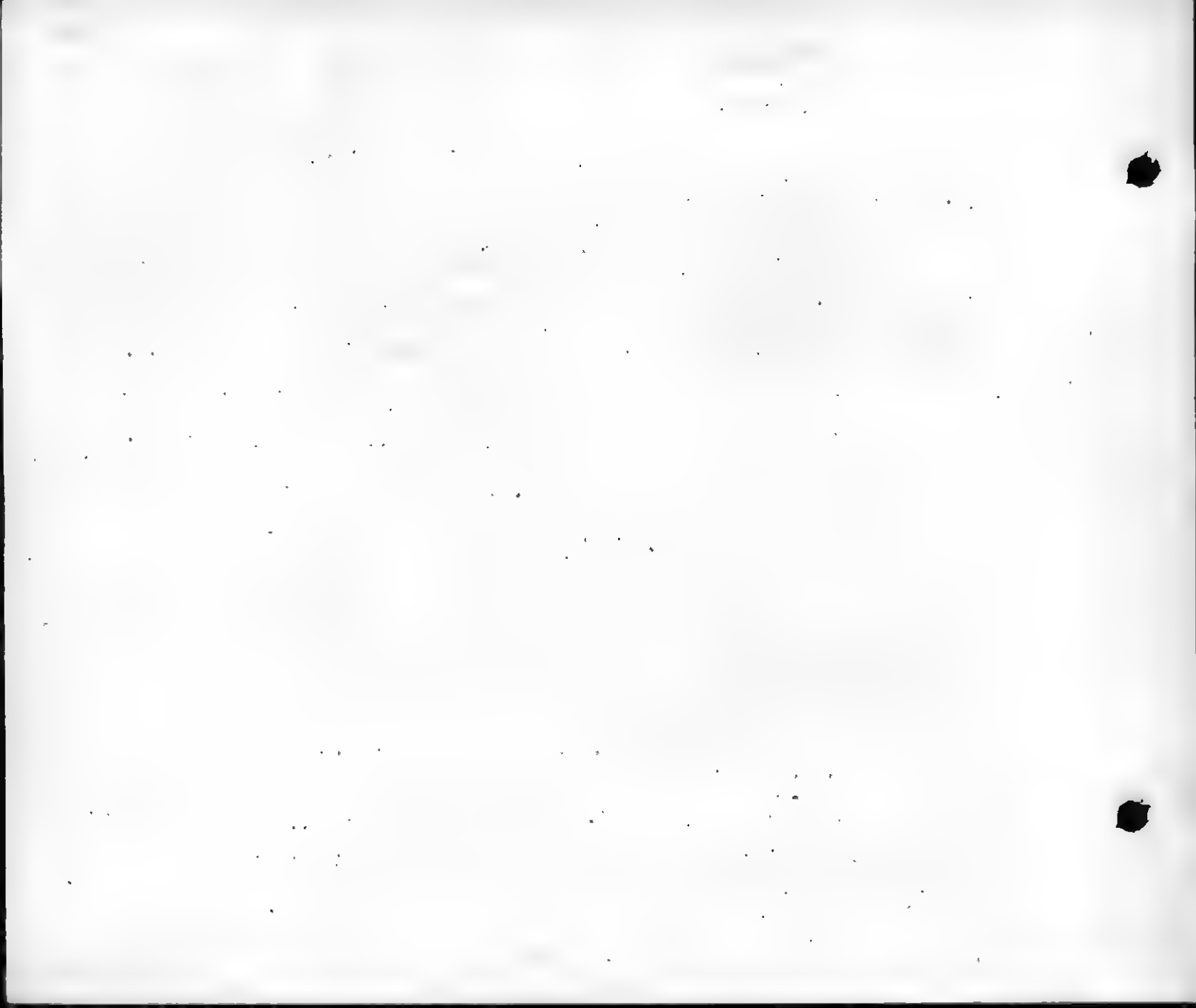
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admision) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Churchton</b>	
3. NAME OF DECEASED (Type or print) First <b>Mollie</b> Middle <b>BLUNT</b> Last <b>BLUNT</b>		4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>19 59</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-19-1895</b>
9. AGE (In years last birthday) <b>64 yrs.</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min <b>7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Daniel Blunt</b>		14. MOTHER'S MAIDEN NAME <b>Nutton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Frank Blunt - Churchton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>443X cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertensive cardiovascular disease</b> DUE TO (c) <b>10 years</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 2, 1959</b> , to <b>Oct. 2, 1959</b> that I last saw the deceased alive on <b>Oct. 2, 1959</b> and that death occurred at <b>12:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edith Rodler</b> M.D.		ADDRESS (Street, city or town, state) <b>45 Franklin St., Annapolis, Maryland</b>	
DATE SIGNED <b>10/5/59</b>			
PHYSICIAN'S NAME (Type) <b>Edith Rodler</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>10-8-59</b>	<b>Franklin</b>	<b>Churchton, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr. - Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 7 1959</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>William Reese</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~fill in~~ use carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

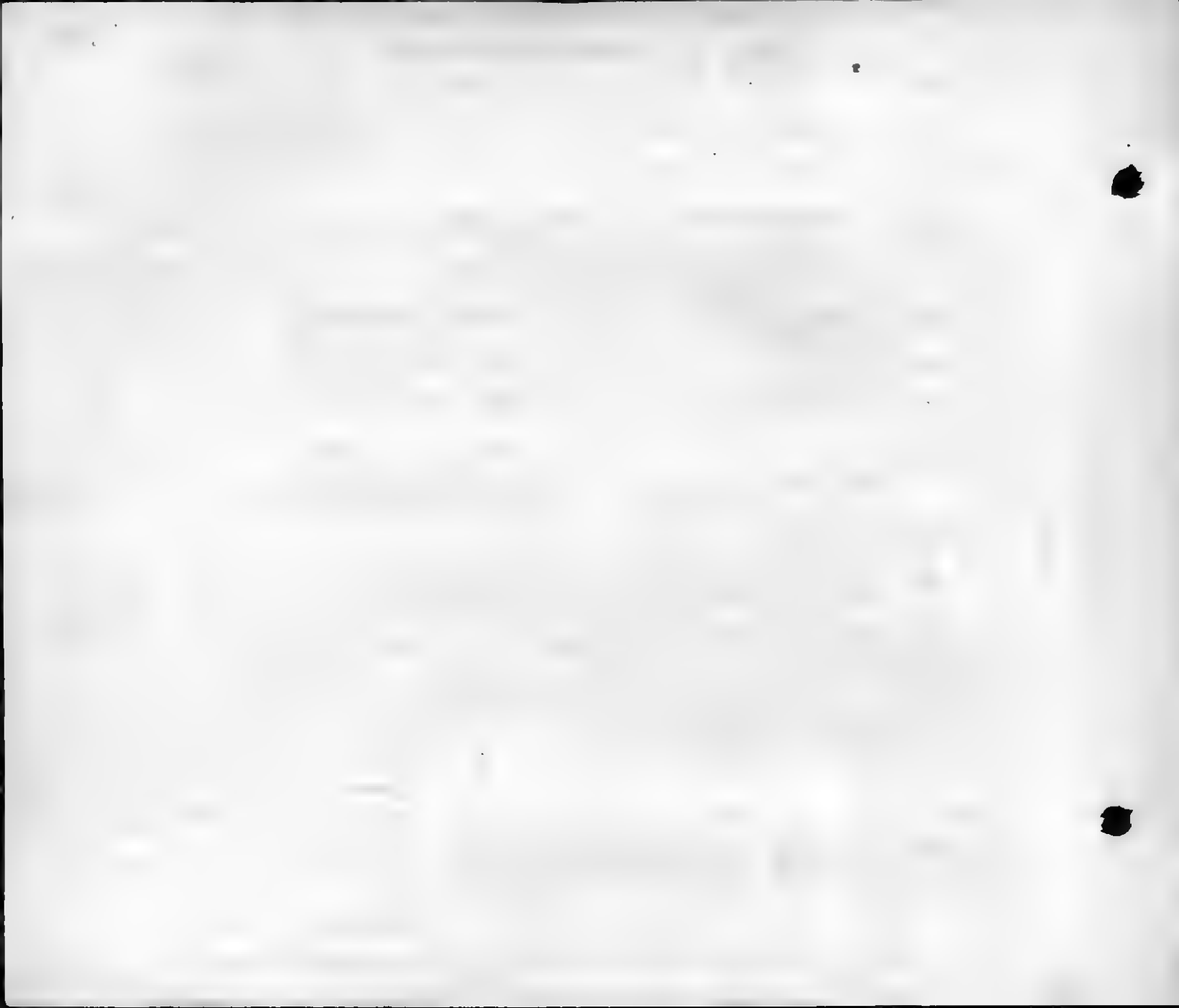
10962

## CERTIFICATE OF DEATH

10909

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fort Meade Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Reuben</u> Middle <u>Boyer</u> Last <u>Boyer</u>				4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>26 Feb. 1879</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>80</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>Severn, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Webster Boyer</u>				14. MOTHER'S MAIDEN NAME <u>Alice Fredhoeffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-38-8141</u>		17. INFORMANT Address <u>Mrs. Dorothy Cbw Severn, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the pancreas</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>0</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>May 1</u> 19 <u>51</u> , to <u>October 10</u> 19 <u>59</u> , that I last saw the deceased alive on <u>October 8</u> 19 <u>59</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>RFD 8 Box 442 Pasadena, Md.</u> DATE SIGNED <u>Oct 10, 1959</u>							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>				PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>14 Oct. 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cem.</u>		22d. LOCATION (City, town, or county) <u>A.A. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR <u>Oct 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. K...</u>	



Items 3, 12 Filed 10-14-59 et

10963

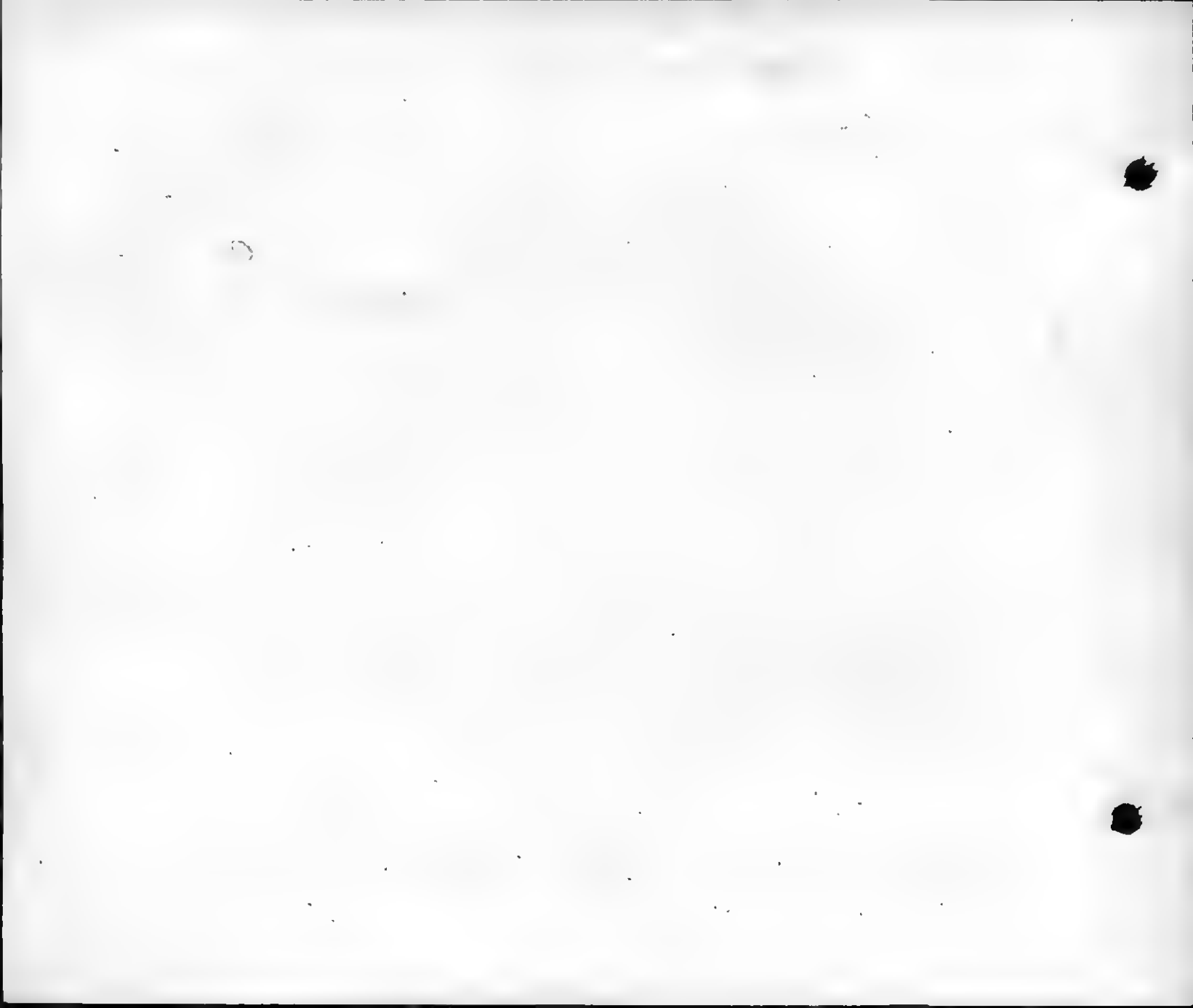
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>M.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE <u>IND.</u> b COUNTY <u>AD.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>200 Kent Rd.</u>		1 d STREET ADDRESS <u>200 Kent Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>BRAZASKAS</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>5</u> - Year <u>1959</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1902</u> <u>3-1-97</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME.</u>	
11. BIRTHPLACE (State or foreign country) <u>LITH.</u>		12 CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Peter Maziatas</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>Family Name</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Adenocarcinoma of Right Ovary</u> DUE TO (c) <u>None</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>1 1/2 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>none</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>none</u>	
20c. TIME OF INJURY Month. Day. Year Hour a m p. m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January</u> 19 <u>59</u> to <u>October 5</u> 19 <u>59</u> that I last saw the deceased alive on <u>October 5</u> 19 <u>59</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>E. Roderick Shipley</u> M.D.			
PHYSICIAN'S NAME (Type) <u>E. Roderick Shipley MD. Medical Arts Bldg. Balto.-Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>B.</u>	<u>10.9.59</u>	<u>Holy Rd.</u>	<u>Balt.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. H. 130 E. Fort Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur H. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

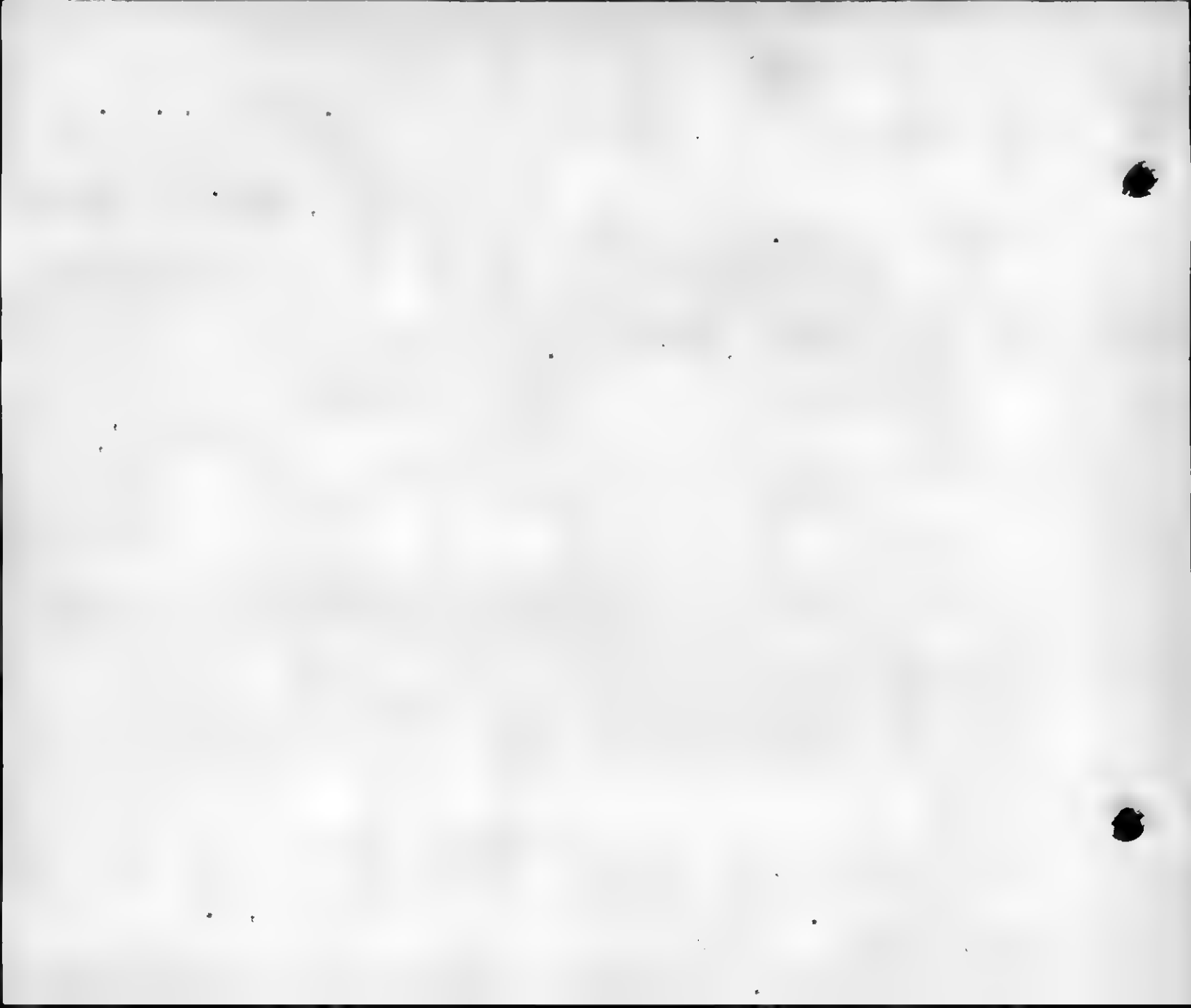
10911

Reg. Dist. No.

10964

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forest Glen</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same Md.</u> b. COUNTY <u>Same A.A. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same Pasadena</u> d. STREET ADDRESS <u>Forest Glen Rd. Same Route 1, Box 307</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <u>William Bricker</u> P First Middle Last				<b>4. DATE OF DEATH</b> <u>October 15th. 19 59</u> Month Day Year													
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>2/25/95</u>		<b>9. AGE</b> (In years last birthday) <u>64 yrs.</u>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS</b> Hours Min.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Salesman and Collector</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Littlepage Furniture Co.</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Berkley County W. Va.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>13. FATHER'S NAME</b> <u>Geramine Bricker</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Virginia Brooke</u>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>215-07-9831</u>				<b>17. INFORMANT</b> <u>Mrs. Virginia Bricker (wife)</u>				Address <u>Box 307, Pasadena, Md</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL, BETWEEN ONSET AND DEATH <u>Sudden</u>																	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
SIGNATURE <u>Gustave H. Faubert</u> EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/16/59</u>											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>Oct. 19/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Western</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Md.</u>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Witzke Funeral Directors</u> <u>4101 Edmondson</u>						<b>24a. REC'D BY REGISTRAR</b> DATE <u>OCT 19 '59</u>						<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10965

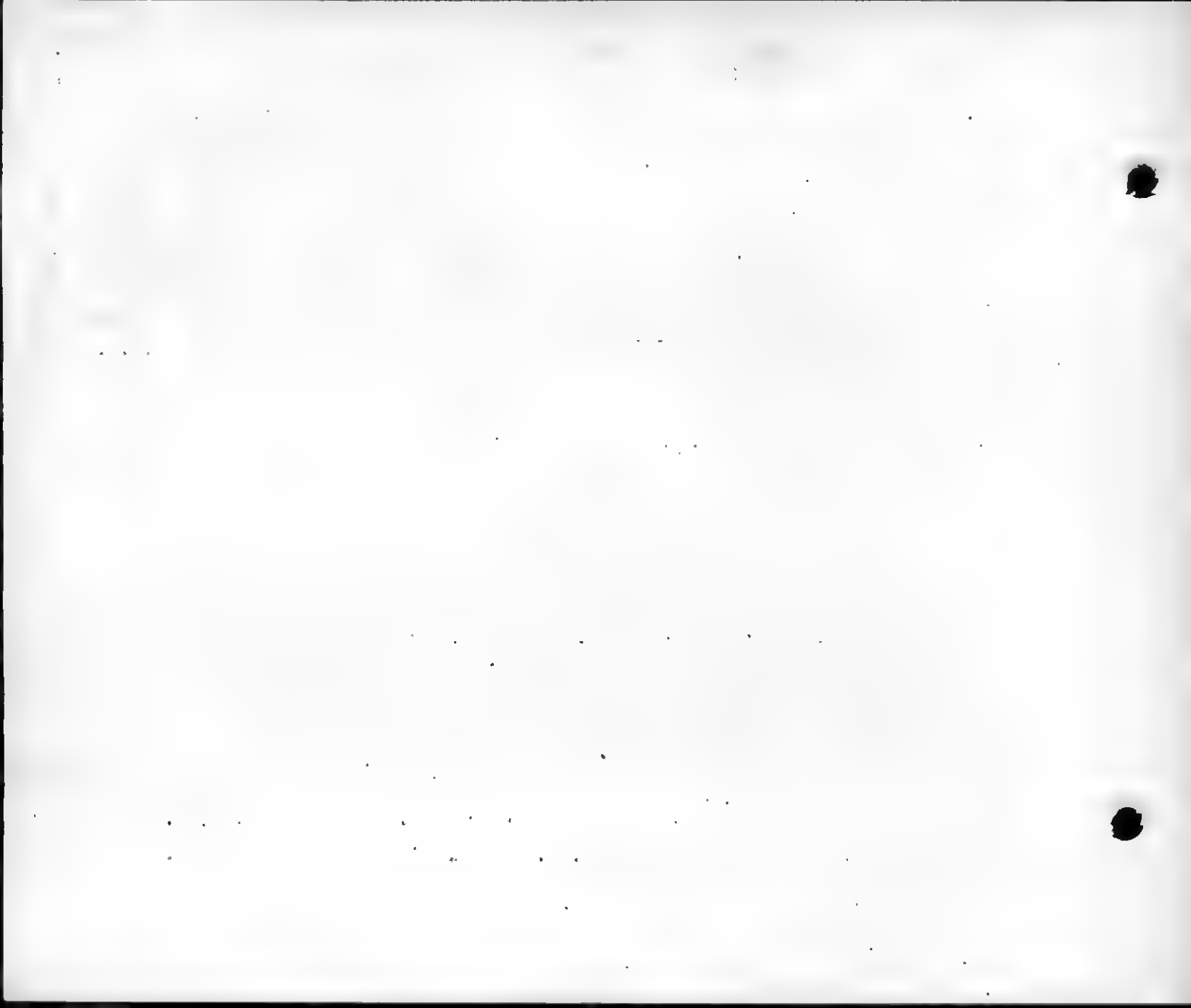
CERTIFICATE OF DEATH

10912

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove capstan papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>9mo. 8days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Margaret's</b>	
d. STREET ADDRESS <b>RFD 2, Box 90</b>									
3 NAME OF DECEASED (Type or print) First Middle Last <b>Keziah Brown</b>			4. DATE OF DEATH Month Day Year <b>10 16 19 59</b>						
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1870</b>	9. AGE (In years last birthday) yrs. <b>88</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>			12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13 FATHER'S NAME <b>Unknown</b>				14 MOTHER'S MAIDEN NAME <b>Unknown</b>					
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Hospital Records</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Decubital Ulcers</b> DUE TO (c) <b>Arteriosclerosis</b>									INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome Associated with Arteriosclerosis</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) -----		20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----		20g. (County) -----		20h. (State) -----					
21. I certify that I attended the deceased from <b>1/8</b> , 19 <b>59</b> , to <b>10/16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/16</b> , 19 <b>59</b> , and that death occurred at <b>12:36</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Hildegard Heard Reissman</b> M.D. <b>Crownsville State Hospital, Md.</b> <b>10/16/59</b> ACTUAL SIGNATURE <b>Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md.</b> <b>10/16/59</b> PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Oct 18 1959</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>St. Margaret's</b>		22d. LOCATION (City, town, or county) <b>Anne Arundel</b>		(State) <b>Md.</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>J. B. Johnson</b>		ADDRESS <b>Annapolis</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thompson</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10913**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>A. A.</b> <span style="float: right;"><b>10920</b></span> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A. A.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS MD</b> d. STREET ADDRESS <b>99 EAST ST.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. LENGTH OF STAY IN <b>Life</b> f. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>99 EAST ST.</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Lucy</b> Middle <b>Briscoe</b> Last <b>Brown</b>		<b>4. DATE OF DEATH</b> Month <b>Oct.</b> Day <b>19</b> Year <b>1959</b>	
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>C</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9-18-1891</b>
<b>9. AGE</b> (In years last birthday) <b>68</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>68</b> Days <b>19</b>	<b>11. IF UNDER 24 HRS.</b> Hours <b>19</b> Min. <b>59</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>—</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>ANNAPOLIS-Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>BENJAMIN BRISCOE</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>UNKNOWN</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>219-30-9975</b>	
<b>17. INFORMANT</b> <b>Joseph Brown-99 East St.</b>		<b>Address</b> <b>ANNAPOLIS-MD</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Cirrhosis Disease</b>  <b>434.4</b>  <b>DUE TO</b>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  <b>(b)</b>  <b>DUE TO</b>  <b>(c)</b> </div> <div style="width: 35%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>1 week</b> </div> </div>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>—</b>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <b>—</b>	
<b>20c. TIME OF INJURY</b> Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>—</b>	<b>20f. (City or town)</b> (County) (State) <b>—</b>
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <b>so unbalet</b>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b> <b>T. L. unbalet</b>		<b>DATE SIGNED</b> <b>10/20/59</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>10-22-59</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>U.S. NATIONAL</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>ANNAPOLIS MD</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Charles E. Hicks III</b>		<b>ADDRESS</b> <b>ANNAPOLIS-MD</b>	
<b>24a. REC'D BY REGISTRAR</b> <b>OCT 26 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Evans</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.  
 VS. A15ME(5)  
 SM 9/55



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

10914

10966

1. PLACE OF DEATH a. COUNTY <u>A. 4.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 9,</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John W. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth M. Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>41-155-5411</u>		17. INFORMANT <u>John W. Brown, Jr.</u> Address <u>100-100 St. N. N. P. H. S. N. P. H. S. N. P. H. S.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 13, 1959</u> to <u>Oct 18, 1959</u> , that I last saw the deceased alive on <u>Oct 13, 1959</u> , and that death occurred at <u>7:45 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Richardson</u>				DATE SIGNED <u>10-19-59</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>10-21-59</u>		<u>10-21-59</u>		<u>10-21-59</u>		<u>10-21-59</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
<u>10-21-59</u>				<u>10-21-59</u>			
24a. REC'D BY REGISTRAR DATE <u>OCT 23 '59</u>				24b. REGISTRAR'S SIGNATURE <u>John L. Thomas</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 2 hours after death. If delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15M  
5M 7/59

15-21 Film 253 **MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10915

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		<b>b. COUNTY</b> <b>Anne Arundel</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN (b) <b>57 Northwest Street</b>		d. STREET ADDRESS <b>57 Northwest Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Sylvia A. Brown</b>		<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>15,</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1-19-1940</b>		9. AGE (In years, last birthday) <b>19</b> yrs.		10. IF UNDER 1 YEAR, Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Richard Brown</b>		14. MOTHER'S M.A.DEN NAME <b>Margaret Murry</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Richard Brown</b>		17. INFORMANT <b>New London, Conn.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>9:50 X</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Syncope during operation for pelvic peritonitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Syncope during operation (Therapeutic misadventure)</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>9:50</b> p.m. <b>10/14/59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	
20f. (City or town) <b>Annapolis</b>		20g. (County) <b>AA</b>		20h. (State) <b>MD.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>10/15/59</b>	
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-18-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>	
22d. LOCATION (City, town, or country) <b>Annapolis Md</b>		22e. REC'D BY REGISTRAR <b>William Reese #108 Wash St Annapolis Md</b>		22f. REGISTRAR'S SIGNATURE <b>William Reese</b>	
22g. FUNERAL DIRECTOR <b>William Reese #108 Wash St Annapolis Md</b>		ADDRESS		DATE <b>Oct 19 1959</b>	

11/11/11

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

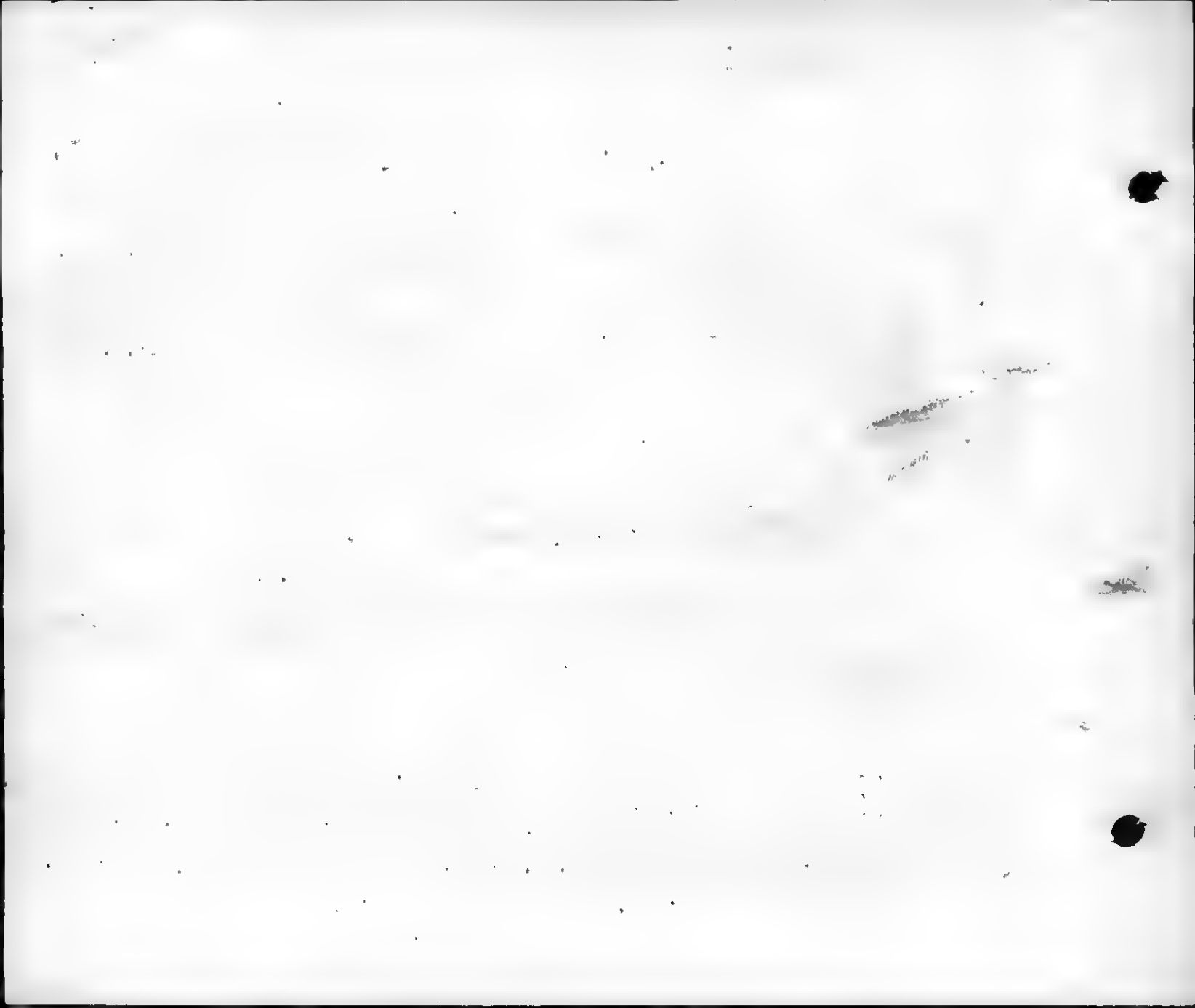
## CERTIFICATE OF DEATH

Reg. Dist. No. 12108

10967

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>11 yrs. 3 mo. 8 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>426 N. Caroline Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Ella</b>		First <b>Ella</b>		Middle <b>Camper</b>		Last <b>Camper</b>		4. DATE OF DEATH Month <b>10</b>		Day <b>23</b>		Year <b>19 59</b>							
5 SEX <b>Female</b>		6 COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1888?</b>		9. AGE (In years last birthday) yrs. <b>71?</b>		IF UNDER 1 YEAR Months <b>71?</b>		IF UNDER 24 HRS Days <b>71?</b>		Hours <b>71?</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Unknown</b>								14. MOTHER'S MAIDEN NAME <b>Unknown</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>				INFORMANT <b>Hospital Records</b>				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Cardio-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>vascular Disease</b>												INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>-----</b>															
20c. TIME OF INJURY Month, Day, Year <b>Nov - 19 59</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>-----</b>				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>7/15</b> , 19 <b>48</b> , to <b>10/23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/23</b> , 19 <b>59</b> , and that death occurred at <b>7:35 A.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>10/23/59</b>																			
ACTUAL SIGNATURE <b>Hildegard Heard Reissman</b>				M.D. <b>Crownsville State Hospital, Md.</b> <b>10/23/59</b>															
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M.D.</b>				<b>Crownsville State Hospital, Md.</b> <b>10/23/59</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>10/27/59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>MT. CATHARY Cem.</b>				22d. LOCATION (City, town, or county) (State) <b>Cedar Hill Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Wilson</b>								ADDRESS <b>1000 Cranberry Ave</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 10 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10922

CERTIFICATE OF DEATH

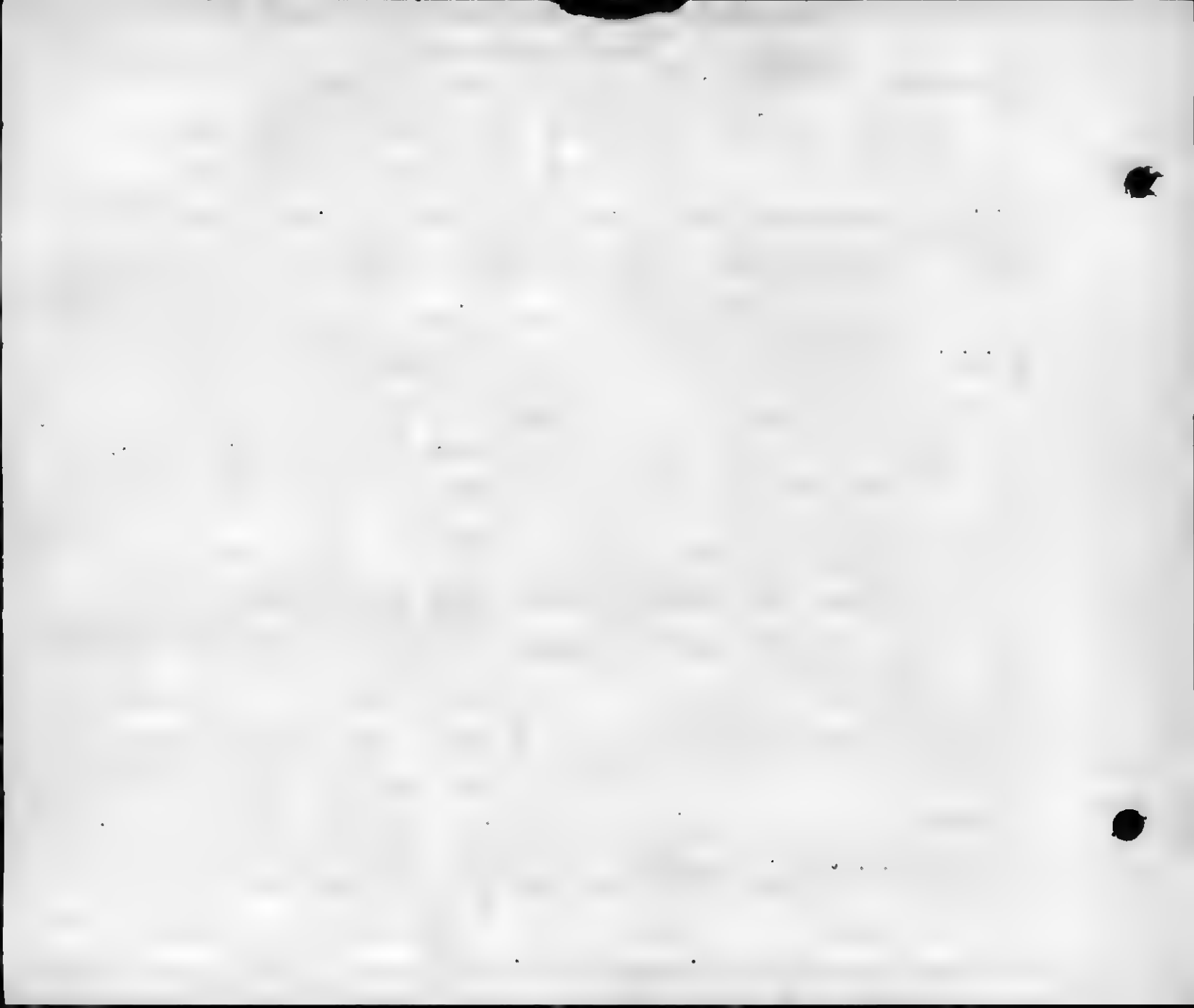
Reg. Dist. No. 10916

1. PLACE OF DEATH a. COUNTY <u>ANNAPOLIS</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNAPOLIS CITY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</u>		d. STREET ADDRESS <u>1313 Stonewood Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>LEE</u> Last <u>COCHRAN</u>		4. DATE OF DEATH Month <u>10</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 Jan., 1916</u>
9. AGE (In years, lost birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>F.B.I.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GOVERNMENT</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>HARRY J. COCHRAN</u>		14. MOTHER'S MAIDEN NAME <u>BEATRICE MURPHY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>KATHLEEN M. COCHRAN</u>		Address <u>1313 STONEWOOD RD., ANNAPOLIS, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>ACUTE MYOCARDIAL INFARCTION</u> IMMEDIATE CAUSE (a) <u>  </u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I attended the deceased from <u>20 October, 1959</u> , to <u>14 October, 1959</u> , that I last saw the deceased alive on <u>14 October, 1959</u> , and that death occurred <u>at 1:35 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</u> DATE SIGNED <u>10-15-59</u> ACTUAL SIGNATURE <u>R.C. Ewing</u> M.D. PHYSICIAN'S NAME (Type) <u>R.C. EWING MD USN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>LONG GREEN MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>  </u>		24a. REC'D BY REGISTRAR <u>  </u>	24b. REGISTRAR'S SIGNATURE <u>  </u>
25. ADDRESS <u>3000 E. Baltimore, Md.</u>		DATE <u>OCT 20 '59</u>	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10968

## CERTIFICATE OF DEATH

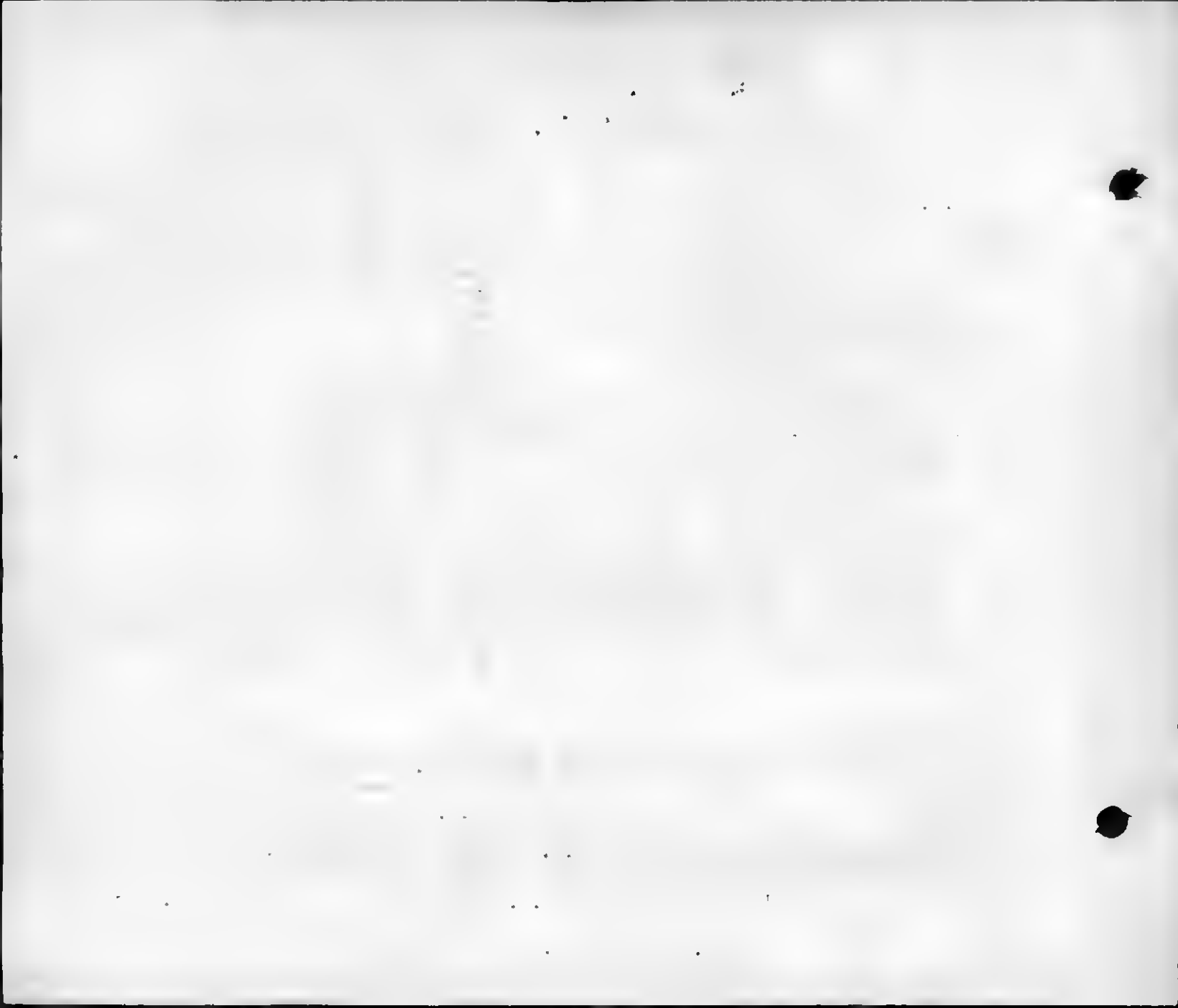
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft Geo G Meade</b>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BOBBY</b> Middle <b>LEE</b> Last <b>COLLINS JR</b>				4. DATE OF DEATH Month <b>October</b> Day <b>30</b> Year <b>19 59</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 Oct 59</b>	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours <b>7</b> Min <b>18</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BOBBY LEE COLLINS Sr</b>				14. MOTHER'S MAIDEN NAME <b>MARY R JENNINGS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT (Father) <b>SP5 Bobby I Collins</b> Address <b>Co A 19th Engr BN Ft Geo G Meade, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>30 Oct</b> , 19 <b>59</b> , to <b>30 Oct</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>30 Oct</b> , 19 <b>59</b> , and that death occurred at <b>10:20 P</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Nathaniel S. Beard, Jr</b> <b>M.D.</b> <b>U.S. Army Hospital</b> <b>31 Oct 59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>NATHANIEL S BEARD Jr Capt M.C.</b> <b>FT GEO G MEADE, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>31 Oct '59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Laboratory, U.S. Army Hospital, Fort George G. Meade, Md</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Betty M. Ellis, Capt., MSC</b>				24a. REC'D BY REGISTRAR <b>NOV 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kneass</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

205026 1X 10



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10918

Reg. Dist. No.

10969

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magothy Beach, Pasadena</u> c. LENGTH OF STAY IN 1b <u>20 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Riverside Drive</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <u>Alice Mary Collins</u> (2nd) (1st) First Last Middle				<b>4. DATE OF DEATH</b> <u>October 12th</u> 19 <u>59</u> Month Day Year															
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7/25/12</u>		<b>9. AGE</b> (In years last birthday) <u>47</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>					
<b>13. FATHER'S NAME</b> <u>Frank Hoerke</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Russell</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>				<b>17. INFORMANT</b> <u>Leo Trageser (Son)</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>									
<b>ACTUAL SIGNATURE</b> <u>Gustave H. Faubert, M.D.</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b>											
<b>EXAMINER'S NAME (Type)</b> <u>Gustave H. Faubert, M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>10/12/59</u>											
<b>22a. BURIAL CREMATION, REBURY (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>14 Oct. 1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Glen Haven Cemo</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>Glen Burnie, Maryland</u>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>R. V. Singleton</u>				<b>ADDRESS</b> <u>Glen Burnie, Md.</u>				<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Orlino S. Huns</u>									
<b>DATE</b> <u>OCT 15 '59</u>																			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, or removal.



**INSTRUCTIONS**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

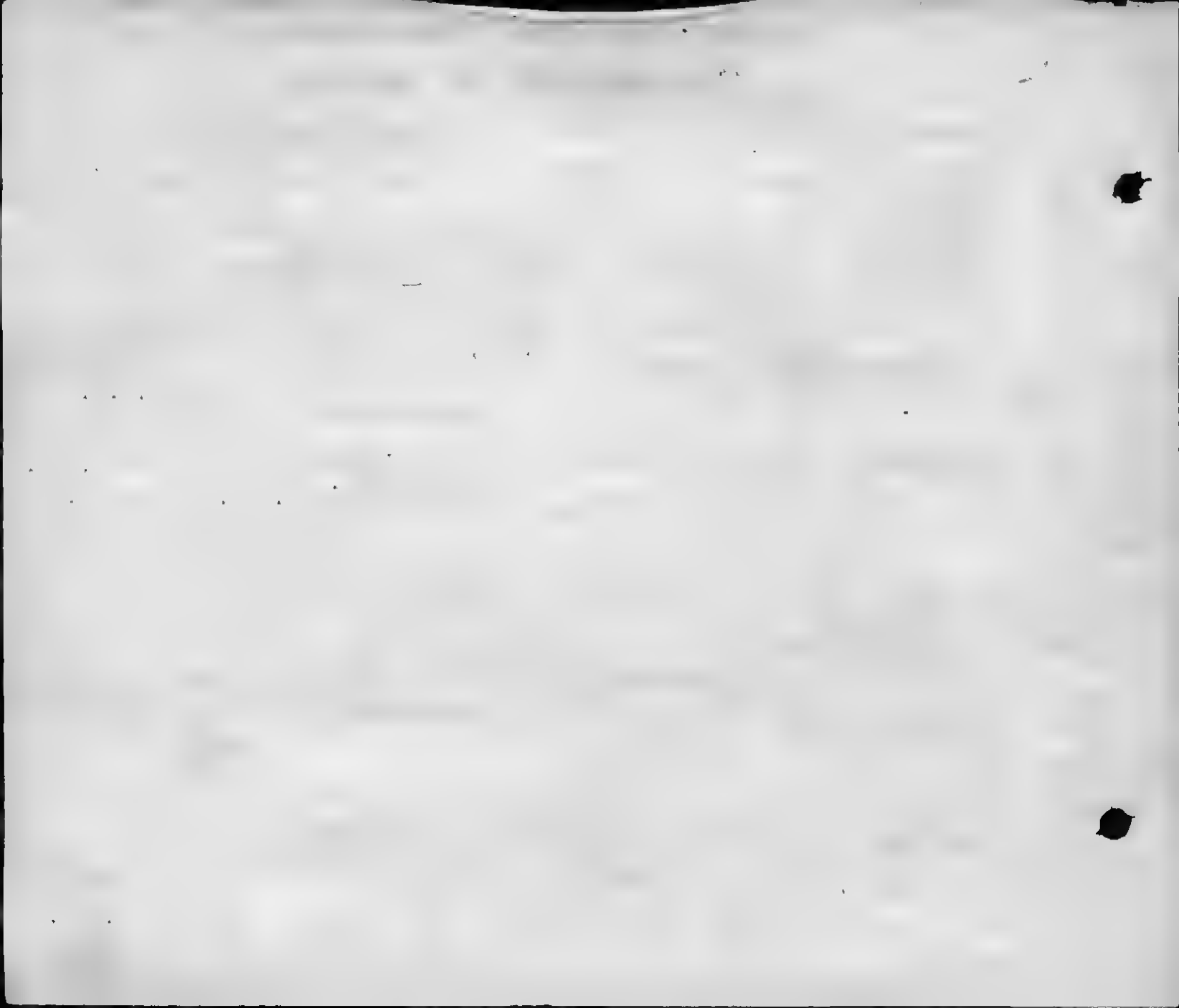
10919

# CERTIFICATE OF DEATH

10923

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>AA CO.</u>		MARYLAND		STATE <u>MA</u>		COUNTY <u>AA CO.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place) <u>10/14-10/26</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WOODROW</u>		TOWN <u>Beach</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood. Cen. Home.</u>				STREET ADDRESS (if rural give location) <u>Shore. Drive.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>MARGARET.</u> (First) <u>CONNEX.</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>10</u> (Day) <u>26</u> (Year) <u>1959</u>			
<b>5. SEX</b> <u>F.</u>	<b>6. COLOR OR RACE</b> <u>W.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>W.</u>	<b>8. DATE OF BIRTH</b> <u>Jan. 19, 1902</u>		<b>9. AGE last birthday</b> <u>57</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Hairdresser</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>William Lokey</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary E. -- ?</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) <u>  </u> (If Yes, give war or dates of service) <u>  </u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>William J. Conner</u> <u>Edgewater, Md.</u> <u>Chesapeake Dr. Rt. 343, Box 3</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Generalized Carcinomatosis.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1957-1959</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>  </u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>  </u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute) <u>  </u> M. <u>  </u> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Jan. 19, 1957</u>, to <u>10/26</u>, 19<u>59</u>, that I last saw the deceased alive on <u>8/26/59</u>, and that death occurred at <u>8:30</u> M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>[Signature]</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>[Signature]</u> <u>10/26/59</u>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>		<b>DATE THEREOF</b> <u>10-29-59</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>OCT 30 '59</u>		<b>REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joe Gawler</u> <u>1756 1/2 ave NW</u> <u>Wash D.C.</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

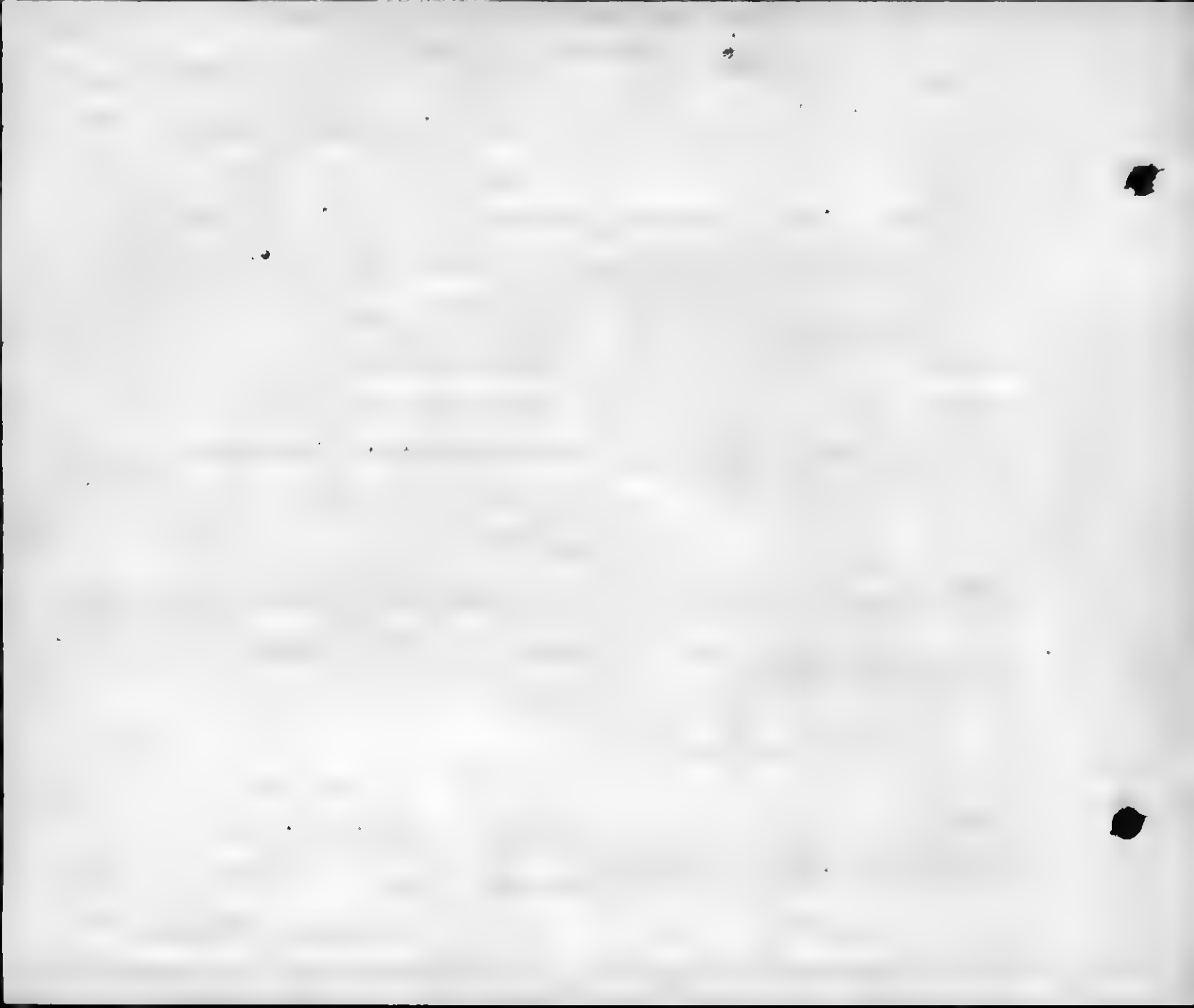
10920

10924

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>24 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>275 Smith Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Louis</u> Last <u>EIRING</u>				4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-13-92</u>	9. AGE (In years last birthday) <u>67</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>USN</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Henry EIRING</u>				14. MOTHER'S MAIDEN NAME <u>Eva HEROLD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>USNH Annapolis, Maryland</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY THROMBOSIS</u> DUE TO (c) <u>ARTEIOSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that I last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>USNH Annapolis, Md.</u> DATE SIGNED <u>10-3-59</u>							
ACTUAL SIGNATURE <u>R. J. DUNN JR</u> M.D.		PHYSICIAN'S NAME (Type) <u>R. J. DUNN JR LT, MC USN</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct-6-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>7 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>		



10921

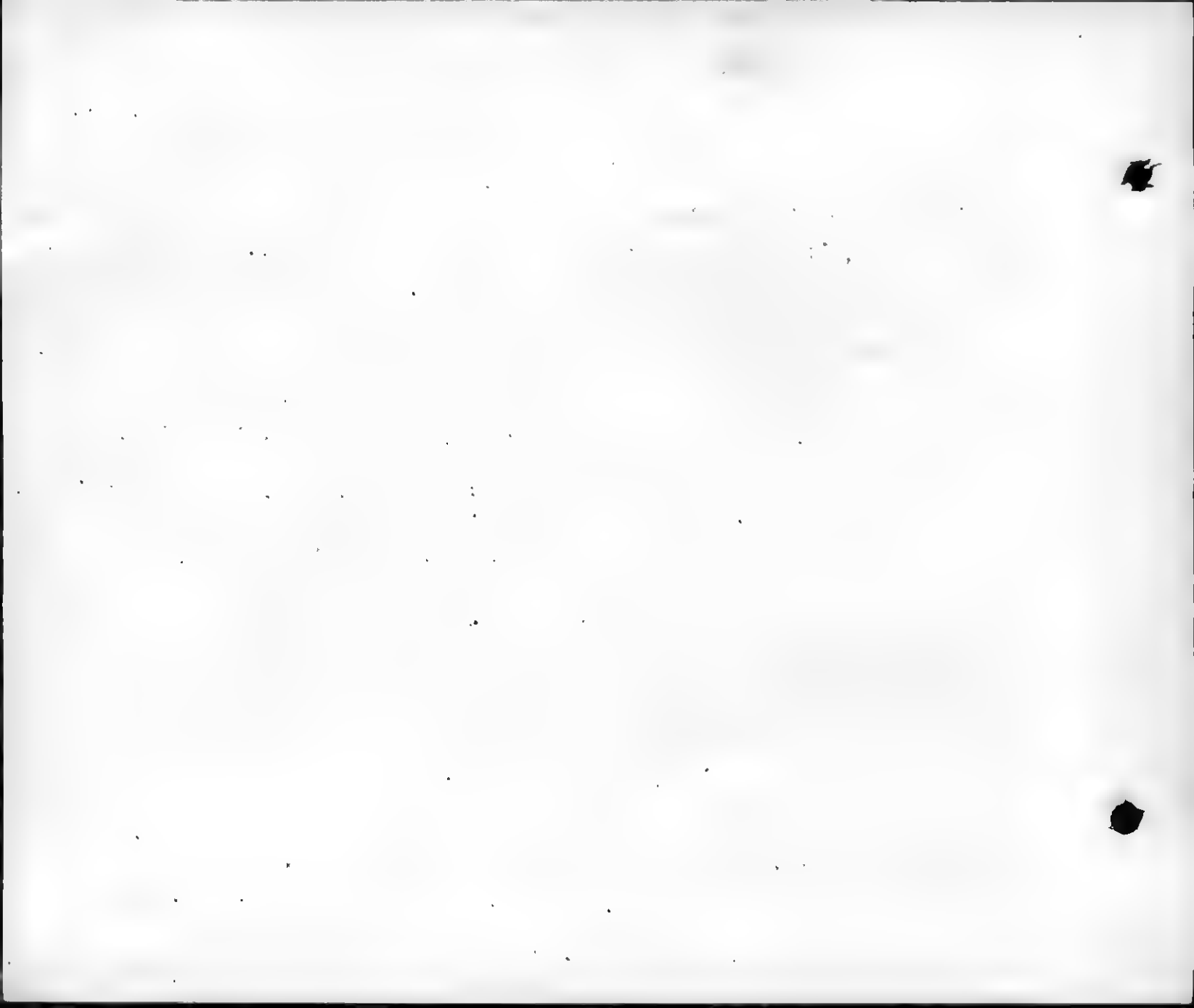
10925

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>8 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Deale</b>	
f. STREET ADDRESS <b>1 Mason's Beach</b>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anna PALMER</b> <b>ERB</b>		4. DATE OF DEATH Month <b>October</b> Day <b>12</b> Year <b>1959</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 8, 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>yes</b>	
17. INFORMANT <b>Arthur P. Erb, Son, Deale, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute pancreatitis &amp; hemorrhagic pneumonia</b> <b>584X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Acute cholecystitis &amp; peri-cystic abscess &amp; extension to pancreas</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Nephrosclerosis, osteoarthritis</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 12, 1959</b> , to <b>Oct 12, 1959</b> , that I last saw the deceased alive on <b>Oct 12, 1959</b> , and that death occurred at <b>11:50 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frederick F. Smith</b> M.D.		ADDRESS (Street, city or town, state) <b>Shadyside, Md.</b>	
PHYSICIAN'S NAME (Type) <b>William F. Smith</b>		DATE SIGNED <b>10/13/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-15-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Congressional</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co. Inc. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>OCT 15 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with this register prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

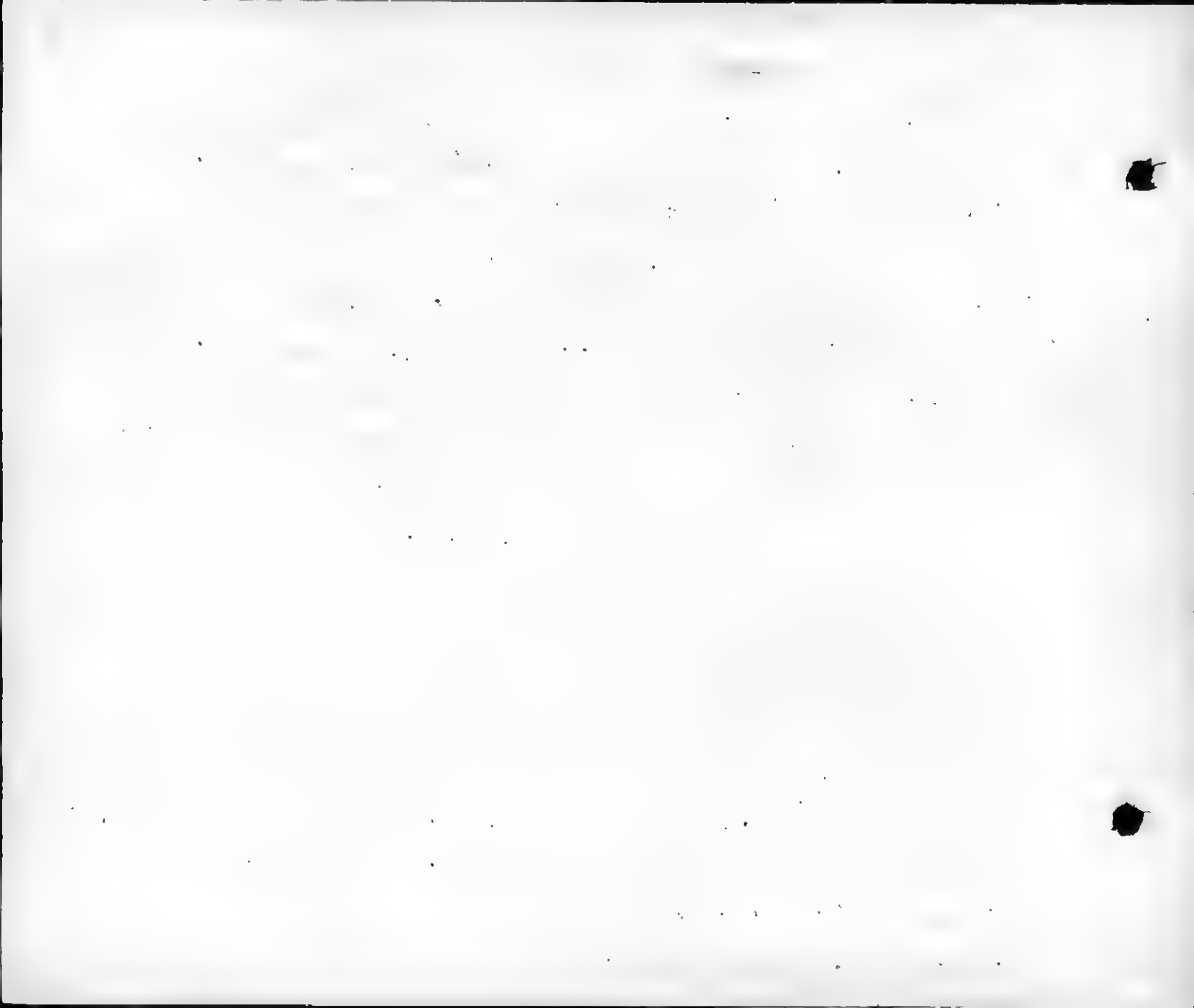
10922

10926

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MD</b> b. COUNTY <b>A.A.C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS RURAL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ANNE ARUNDEL GENERAL HOSPT.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANK PRESTON FIFER</b>		4. DATE OF DEATH Month Day Year <b>OCT. 30 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 18, 1885</b>
9. AGE (In years, last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HYDRO CIVIL ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION ENGINEER</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM FIFER</b>		14. MOTHER'S MAIDEN NAME <b>MARY BAILEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>DOROTHY WALKER FIFER #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cute in myocardial brownops</b> 4 av. 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cute coronary Thrombosis</b> DUE TO (c) <b>5 day</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1956</b> to <b>OCT 30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>OCT 30</b> , 19 <b>59</b> , and that death occurred at <b>7:40</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John L. Hedeman</b>		ADDRESS (Street, city or town, state) <b>121 CATHEDRAL ST. ANNAPOLIS MD</b>	
PHYSICIAN'S NAME (Type) <b>ANNAPOLIS MD</b>		DATE SIGNED <b>10/31/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>NOV 2 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>DRUID RIDGE CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>PIKESVILLE MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. TAYLOR</b>		24a. REC'D BY REGISTRAR <b>NOV 4 '59</b>	
ADDRESS <b>SON ANNAPOLIS MD</b>		24b. REGISTRAR'S SIGNATURE <b>Caroline E. K...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10927

## CERTIFICATE OF DEATH

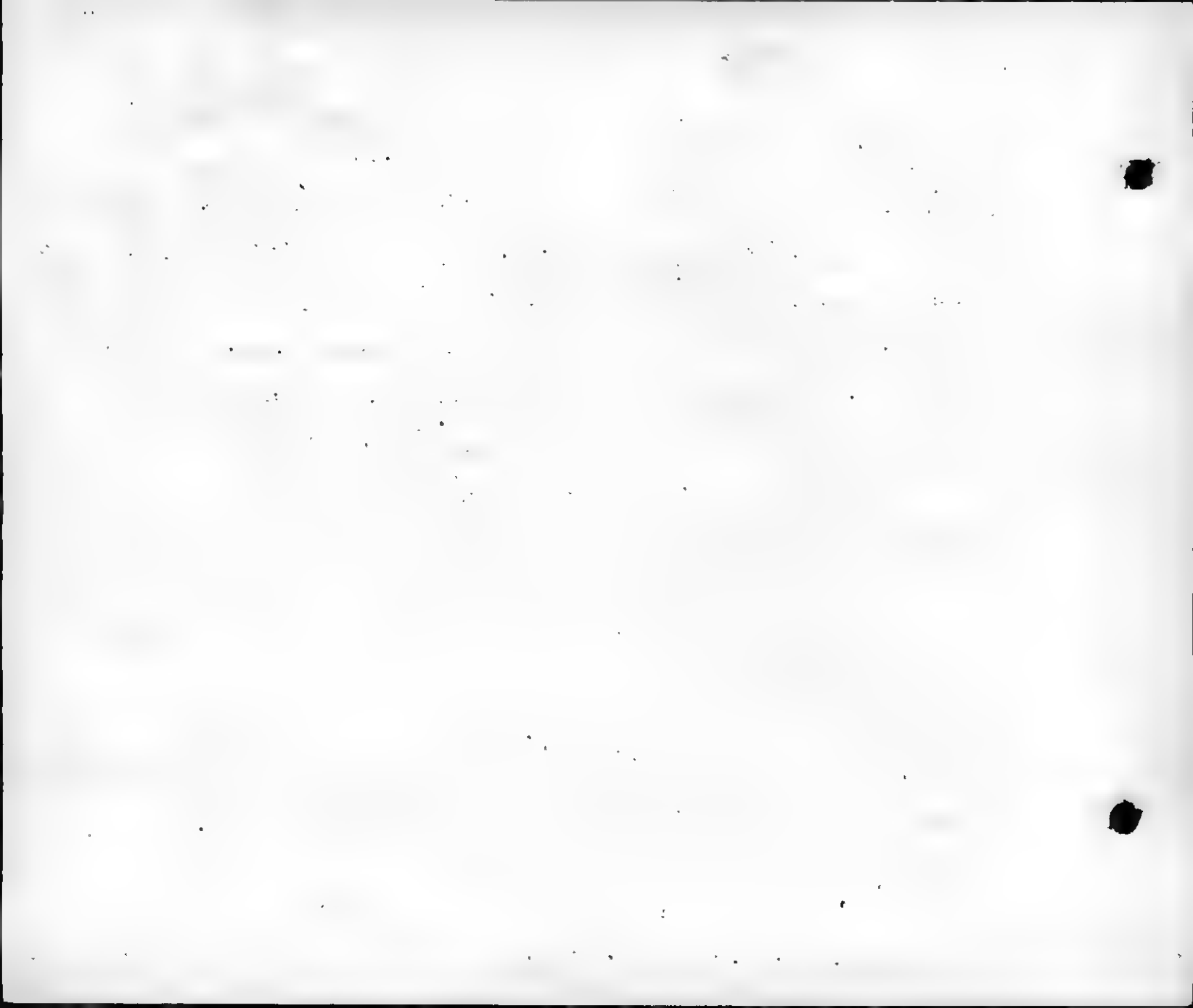
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General Hospital</i>		e. STREET ADDRESS <i>98 Monticello Ave.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>SARAH E. FRANK</i>		4. DATE OF DEATH Month Day Year <i>OCT 24 1959</i>	
5 SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 25<sup>th</sup> 1891</i>
9. AGE (In years last birthday) yrs <i>68</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Anne Arundel Co Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph J. Stevens</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ann Elliott</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>		16. SOCIAL SECURITY NO INFORMANT Address <i>George C. Frank #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute pulmonary embolism</i> 165 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>August</i> , 19 <i>59</i> , to <i>October</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Oct. 23</i> , 19 <i>59</i> , and that death occurred at <i>4:30</i> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>John C. Hedeman</i> M.D. <i>Annapolis Md</i>			
PHYSICIAN'S NAME (Type)			
22a. BJR A. INFORMATION REMOVAL (Specify)	22b. DATE THEREOF <i>OCT 27 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>CEDAR BLUFF</i>	22d. LOCATION (City, town, or county) (State) <i>ANNAPOLIS MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>JOHN M. TAYLOR SON ANNAPOLIS MD</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 27 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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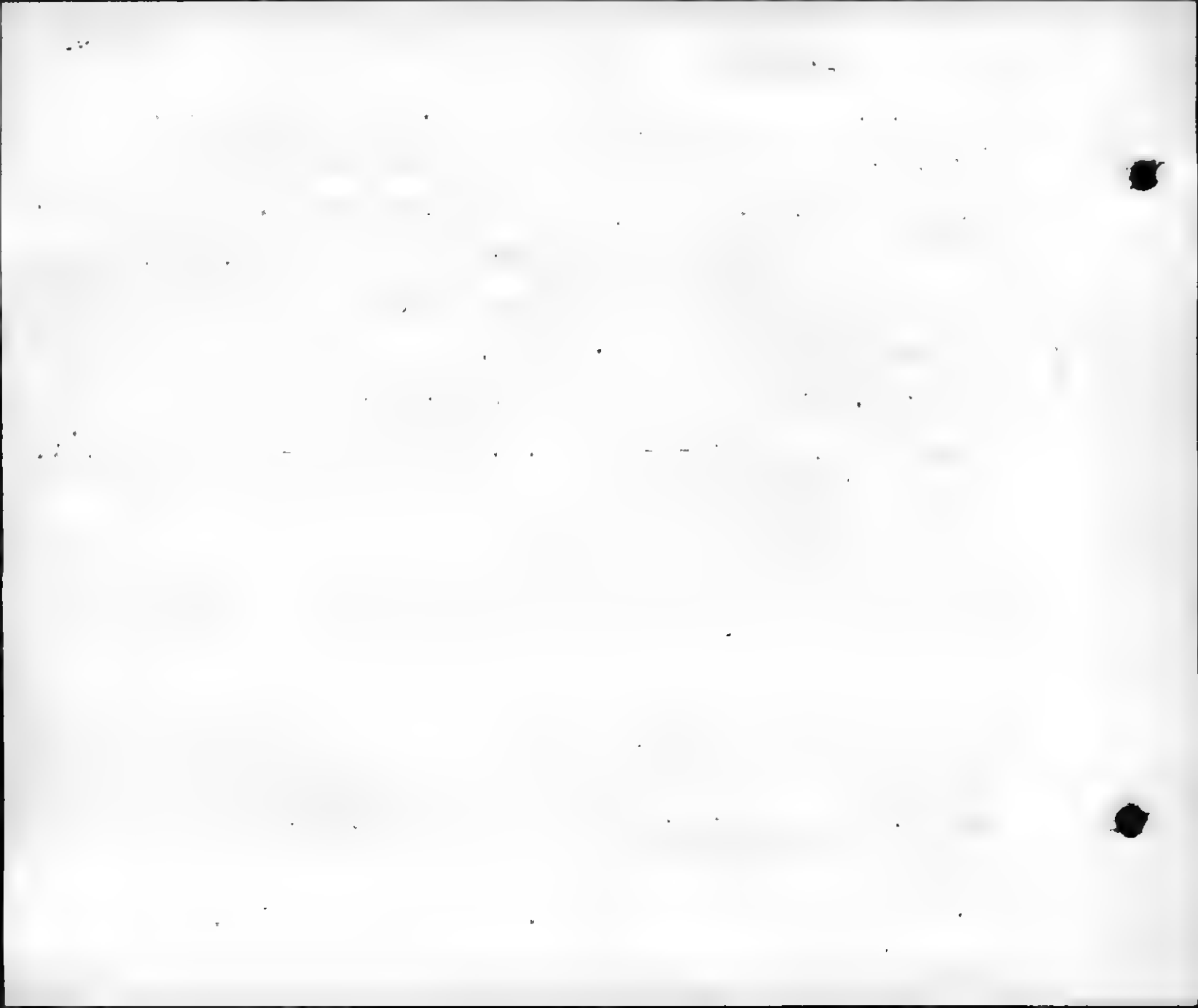


10970

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>A. A.</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A. A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carvel Beach</b>		c. LENGTH OF STAY IN 1b <b>X</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>458 Carvel Beach Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>MAE</b> Last <b>FRYFOGLE</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>1</b> Year <b>19 59</b>	
5 SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 30, 1908</b>
9 AGE (In years last birthday) <b>51 yrs</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles W. Lochhead</b>		14. MOTHER'S MAIDEN NAME <b>Mabel Britton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>217-16-7622</b>	
17. INFORMANT <b>Mr. A. Carney Fryfogle - 458 Carvel Beach Rd.</b>		18. ADDRESS <b>Carvel Beach, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b> <b>1 Hour</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Diabetes Mellitus ; Carcinoma of Cervix</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 12, 1956</b> to <b>Sept. 22, 1959</b> , that I last saw the deceased alive on <b>Sept 22, 1959</b> , and that death occurred at <b>P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Sylvia D. Greenberg M.D. Medford Ave. Chevy Chase, Md. 10/2/59</b>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/5/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William J. Lieberman</b>		24a. REC'D BY REGISTRAR <b>6 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Howard</b>			



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

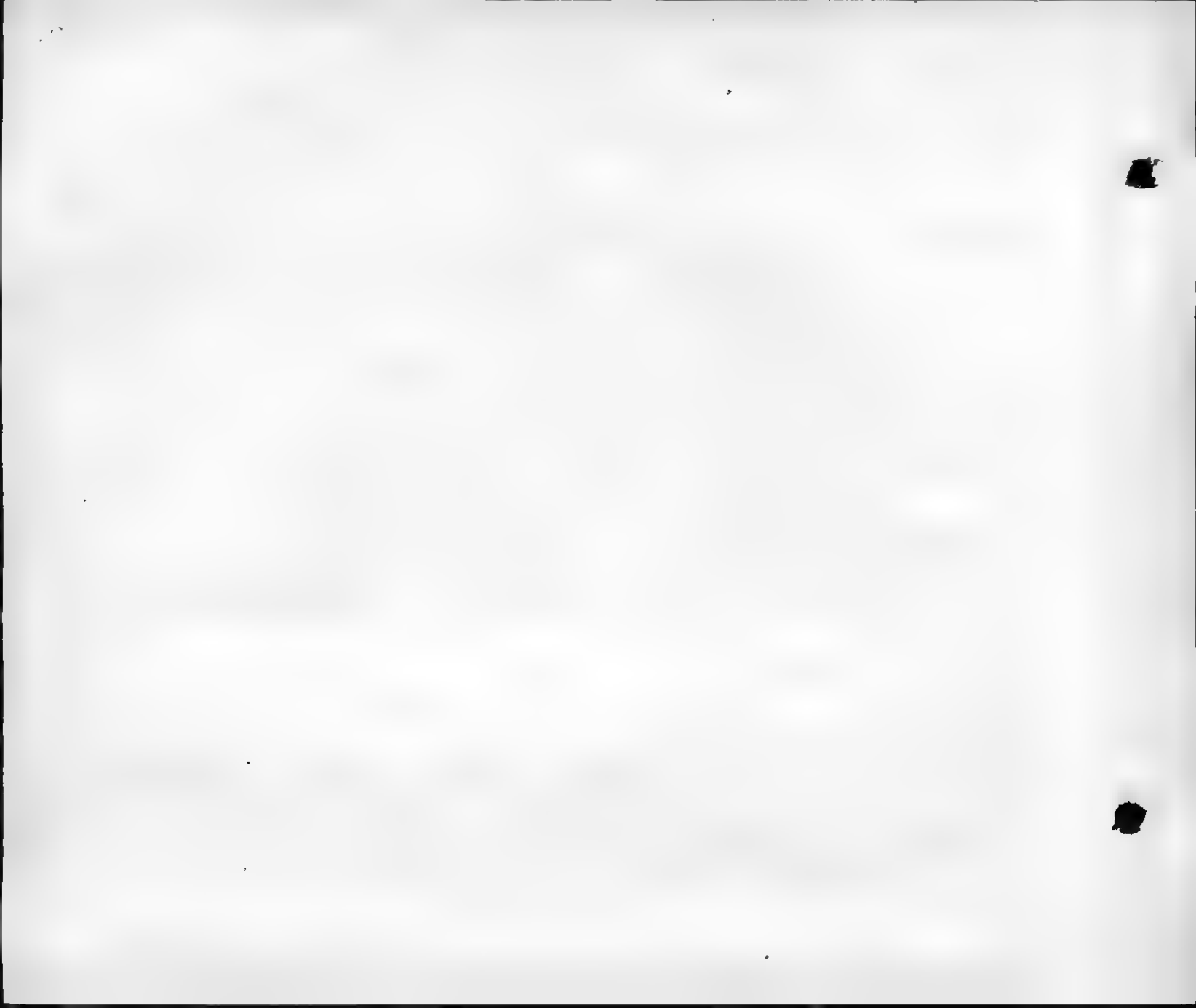
## 10971

### CERTIFICATE OF DEATH

10925

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>AA</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PASADENA</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rock Creek - Ft. Smallwood Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sally</b> Middle <b>-</b> Last <b>FURLONG</b>		4. DATE OF DEATH Month <b>10</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-16-77</b>
9. AGE (in years lost birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>18</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS Months <b>8</b> Days <b>18</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO <b>-</b>	
17. INFORMANT <b>DA Co welfare</b>		Address <b>Annapolis, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 1957, to <b>Oct 4</b> , 1959, that I last saw the deceased alive on <b>Oct-1</b> , 1959, and that death occurred at <b>3:00 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>8471 FT. SMALLWOOD RD PASADENA, MD.</b> DATE SIGNED <b>10/5/59</b>			
ACTUAL SIGNATURE <b>J. Brady Smith</b>		M.D. <b>8471 FT. SMALLWOOD RD PASADENA, MD.</b>	
PHYSICIAN'S NAME (Type) <b>J. BRADY SMITH</b>		PASADENA, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-6-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. VETERANS</b>		22d. LOCATION (City, town, or county) (State) <b>Spa. h.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mc Cully Funeral Homes</b>		ADDRESS <b>130 E. Fort Ave.</b>	
24a. REC'D BY REGISTRAR <b>OCT 6 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Harris</b>	



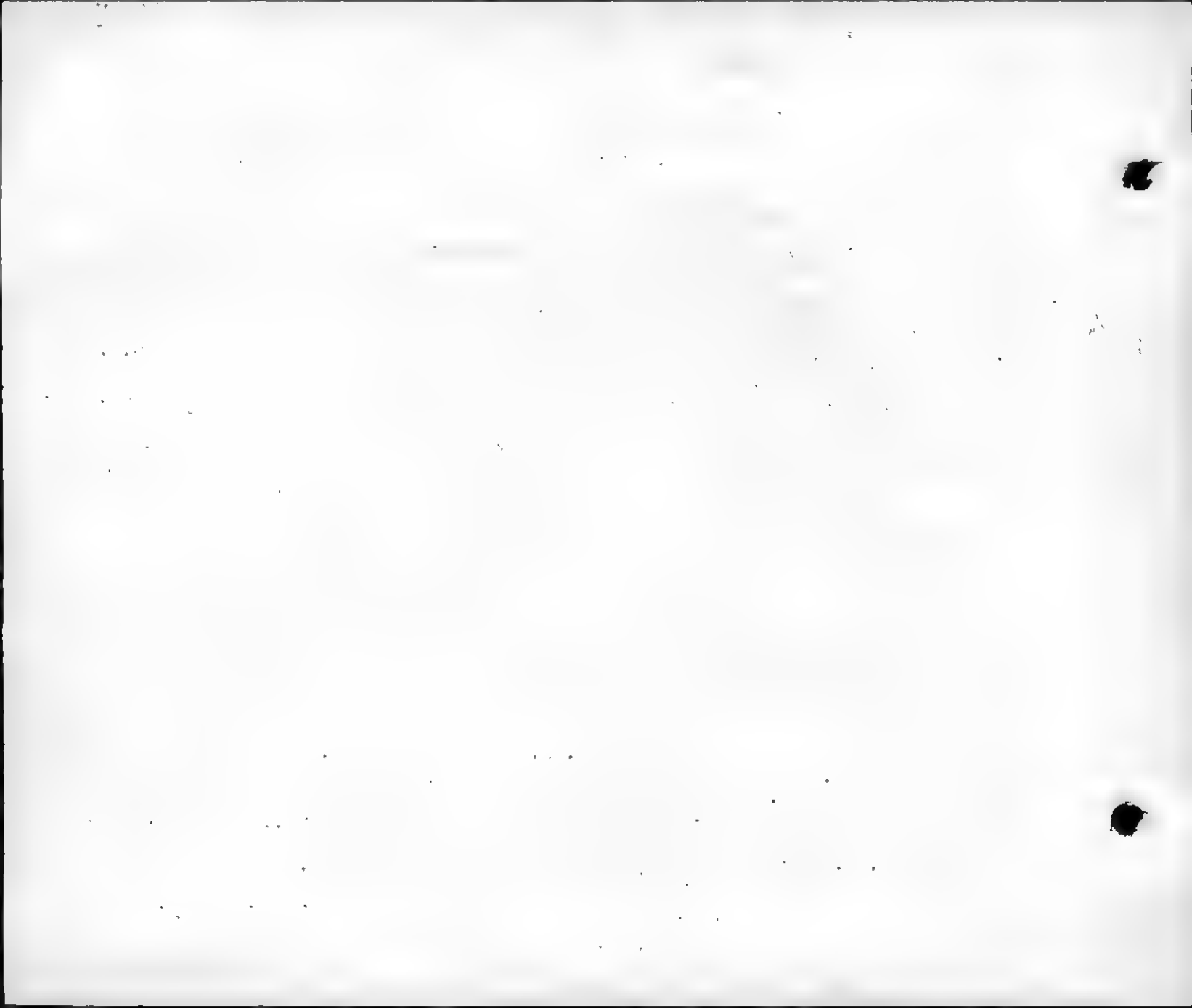
10928

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>4 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Louiseanna Gambrille</b>		4. DATE OF DEATH Month Day Year <b>October 1 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-15-1911</b>
9. AGE (In years last birthday) <b>48 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Alke Abrams</b>		14. MOTHER'S MAIDEN NAME <b>Georgeanna Chews</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Horace Gambrille Jones Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331x Cerebro vascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 1, 1959</b> , to <b>Oct. 1, 1959</b> , that I last saw the deceased alive on <b>Oct. 1, 1959</b> , and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>P. T. Allen</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>62 Cathedral St., 10/2/59</b>	
PHYSICIAN'S NAME (Type) <b>A. T. Allen</b>		<b>Annapolis, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-4-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wayman Wood Home</b>		22d. LOCATION (City, town, or county) (State) <b>Severna Park Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese #108 Wash. St. Annapolis</b>		24a. REC'D BY REGISTRAR <b>OCT 6 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 X  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10972

## CERTIFICATE OF DEATH

10927

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>207 n.s.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>26-Georgia Ave. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Amanda</u> Middle <u>M.</u> Last <u>Gehne</u>		4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 Feb. 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN (Kuehl)</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>100 Central Ave. Glen Burnie</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 1951</u> to <u>Oct. 1952</u> , that I last saw the deceased alive on <u>11-6-59</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. R. MacDonell</u>		ADDRESS (Street, city or town, state) <u>11-12-51</u>	
PHYSICIAN'S NAME (Type) <u>C. R. MacDonell MD</u>		DATE SIGNED <u>11-12-51</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>15 Oct. 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore City MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Singleton</u>		ADDRESS <u>Glen Burnie MD</u>	
24a. REC'D BY REGISTRAR <u>OCT 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>	



CERTIFICATE OF DEATH

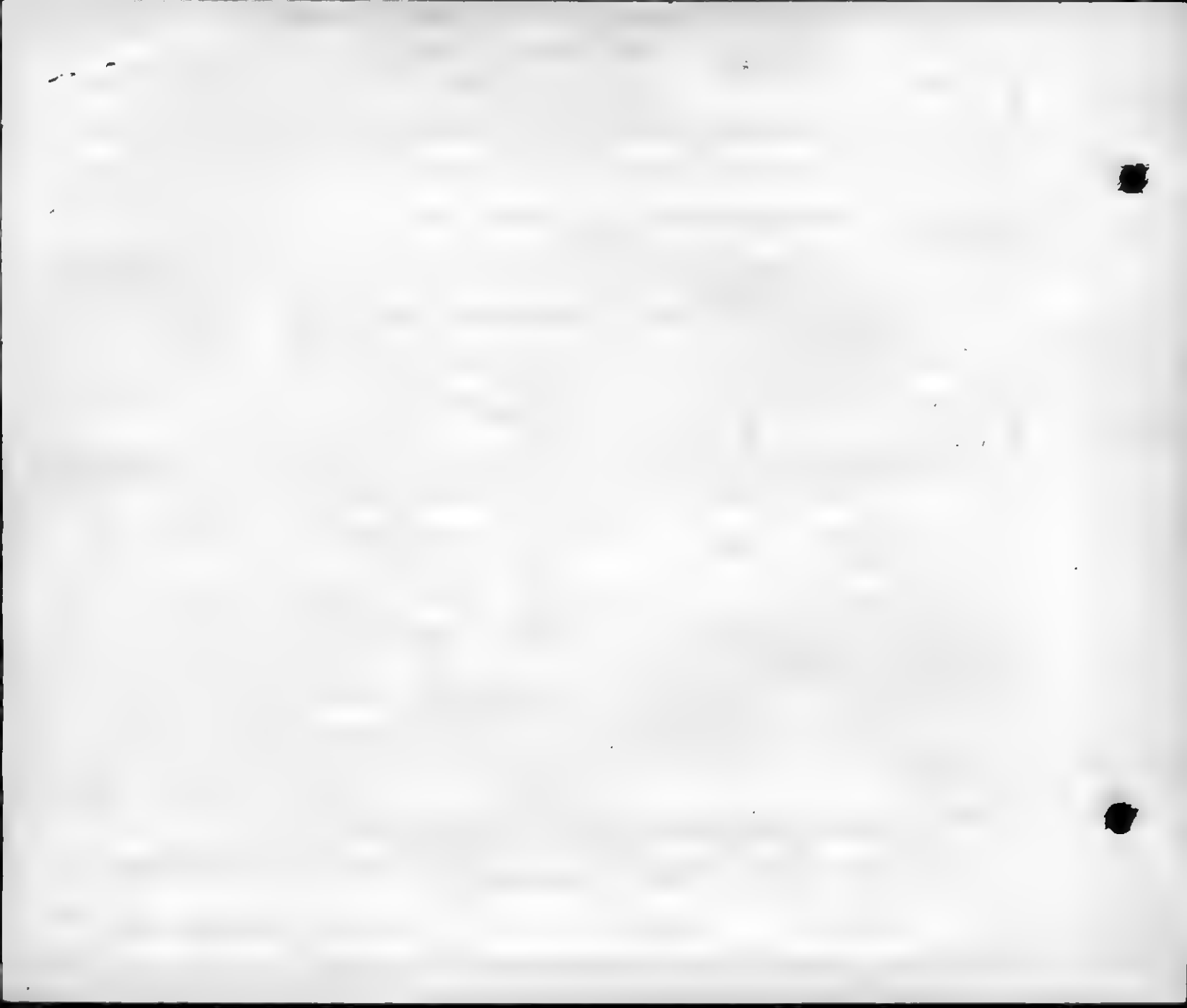
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riviera Beach</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Riviera Beach</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>266 Carroll - Road</u>				d. STREET ADDRESS <u>266 Carroll - Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Giblette</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>15 Oct. 1886</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>Greenwood, Mo.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Greenwood, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph F. Witrow</u>				14. MOTHER'S MAIDEN NAME <u>Florella M<sup>e</sup> Kirahan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>John F. Giblette, Same as NO-(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchopneumonia</u> <u>170X</u> DUE TO (b) <u>Generalized Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Carcinoma nt. Breast</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>1 YR.</u> <u>2 YRS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>AUG 15</u> , 1959, to <u>OCT. 18</u> , 1959, that I last saw the deceased alive on <u>OCT. 18</u> , 1959, and that death occurred at <u>2:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u>				DATE SIGNED <u>MOUNTAIN RD.</u>			
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR.</u>				<u>PASADENA, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>22 Oct. 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Benton Co. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sauk Rapids Minn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert P. Ware - Glen Burnie, Md</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carroll</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



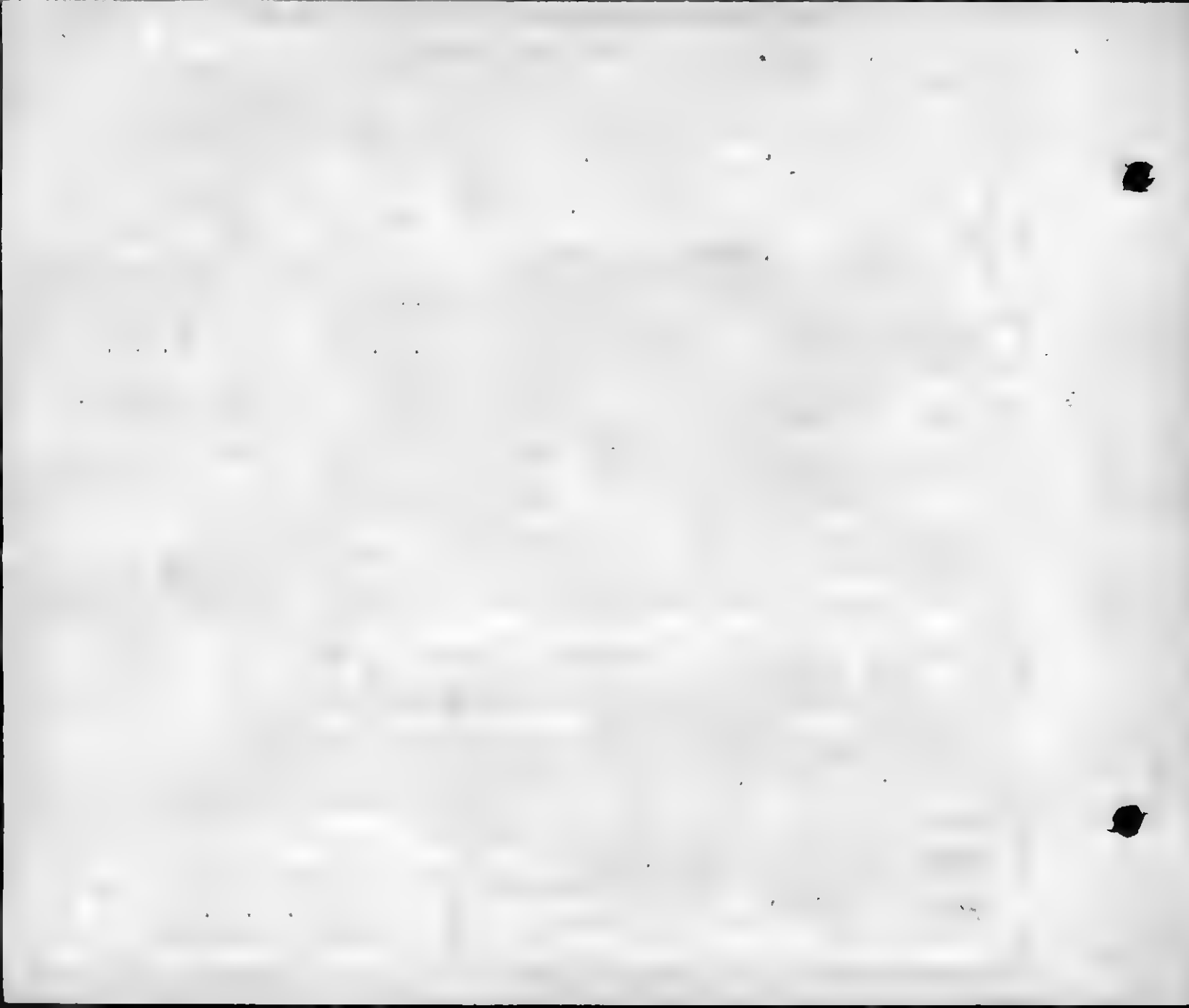
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 10974 CERTIFICATE OF DEATH

10929

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>				c. LENGTH OF STAY IN 1b <u>29 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ritchie Highway &amp; Annapolis Rd.</u>				d. STREET ADDRESS <u>Rithie Highway &amp; annapolis Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter J. (Goszka) Goska</u>				4. DATE OF DEATH Month Day Year <u>October 5, 19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 2, 1892</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storkepper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Groceries</u>		11. BIRTHPLACE (State or foreign country) <u>Balto.Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stanley Goszka</u>				14. MOTHER'S MAIDEN NAME <u>Mary Grembocka Severna Park, Md.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-34-0084</u>		17. INFORMANT Address <u>Helen Goska</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate with metastasis</u> DUE TO <u>Inoperable</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>September, 19 56</u> , to <u>October, 19 59</u> , that I last saw the deceased alive on <u>Oct 3, 19 59</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Severna Park, Maryland</u> DATE SIGNED <u>10-5-59</u> ACTUAL SIGNATURE <u>Francis I. Codd</u> M.D. PHYSICIAN'S NAME (Type) <u>Francis I. Codd M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		22d. LOCATION (City, town, or county) (State) <u>Balto.Co.Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Fialkowski</u>				ADDRESS <u>2007 Eastern ave.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 7 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>John J. Paul</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10975

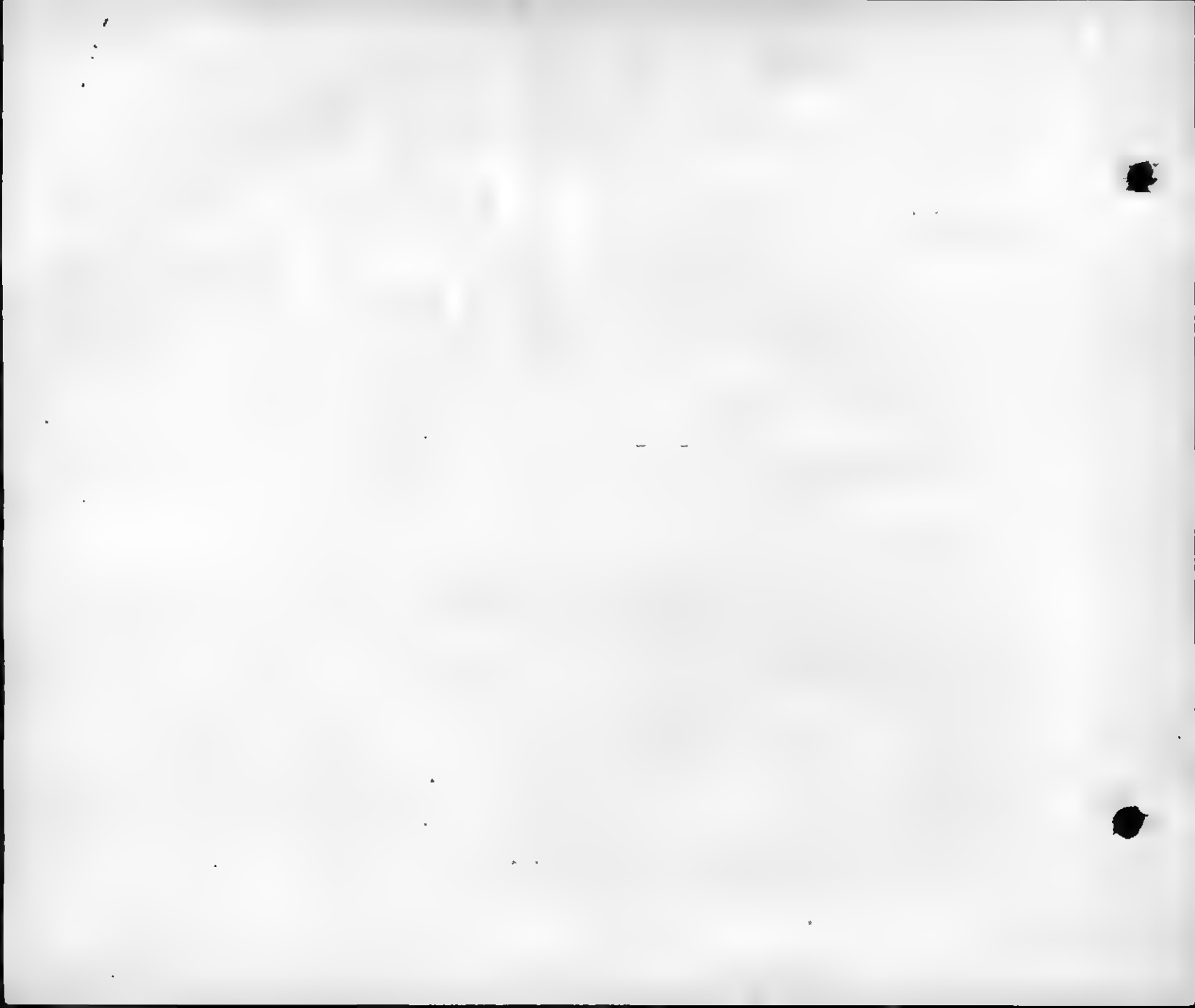
## CERTIFICATE OF DEATH

10930

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft Geo G Meade</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Ohio</b>		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>		e. STREET ADDRESS <b>754 S Walnut St</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>WILSON</b>		Middle <b>ARTHUR</b>		Last <b>GOUTY</b>		4. DATE OF DEATH Month <b>October</b>		Day <b>30</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 December 1885</b>		9. AGE (In years last birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Henry Gouty</b>				14. MOTHER'S MAIDEN NAME <b>Rachel Decker</b>					
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>281-1647676</b>		17. INFORMANT <b>(Son) Sfc Harold Gouty</b>		Address <b>USA Hosp Ft Geo G Meade, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <b>19 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>30 Oct</b> , 19 <b>59</b> , <b>30 Oct</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>30 Oct</b> , 19 <b>59</b> , and that death occurred at <b>5.10 P.</b> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Nathaniel S. Beard Jr</b>		ADDRESS (Street, city or town, state) <b>U.S. ARMY HOSPITAL</b>		DATE SIGNED <b>31 Oct 59</b>					
PHYSICIAN'S NAME (Type) <b>NATHANIEL S. BEARD Jr Capt M.C.</b>		<b>Ft Geo G Meade, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery</b>		22d. LOCATION (City, town, or county)		(State) <b>Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert F. Adams</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>NOV 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



10976

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Md.</u>		c. LENGTH OF STAY IN 1b <u>9 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>District Training School, Children's Center, Laurel, Md.</u>		d. STREET ADDRESS <u>3905 Burns Place, S.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Steven</u> Middle <u>Anthony</u> Last <u>Greene</u>		4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/7/55</u>
9. AGE (In years last birthday) <u>4</u> yrs		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Lee Ellis Greene</u>	
14. MOTHER'S MAIDEN NAME <u>Gerardine Mary Bryant</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>Social Service, Children's Center, Laurel, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration with pneumonia</u> <u>752 x</u> DUE TO (b) <u>Hydrocyphalus - congenital</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Mental and physical retardation</u>			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>1/15/59</u> , 19____, to <u>10/19/59</u> , 19____, that I last saw the deceased alive on <u>10/19/59</u> , 19____, and that death occurred at <u>1:45</u> AM, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>George Glass</u> M.D.		ADDRESS (Street, city or town, state) <u>Children's Center, Laurel, Md.</u> DATE SIGNED <u>10/19/59</u>	
PHYSICIAN'S NAME (Type) <u>George Glass, M.D.</u>		<u>Children's Center, Laurel, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malmon and Lekey</u> ADDRESS <u>424 R St NW</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10977

# CERTIFICATE OF DEATH

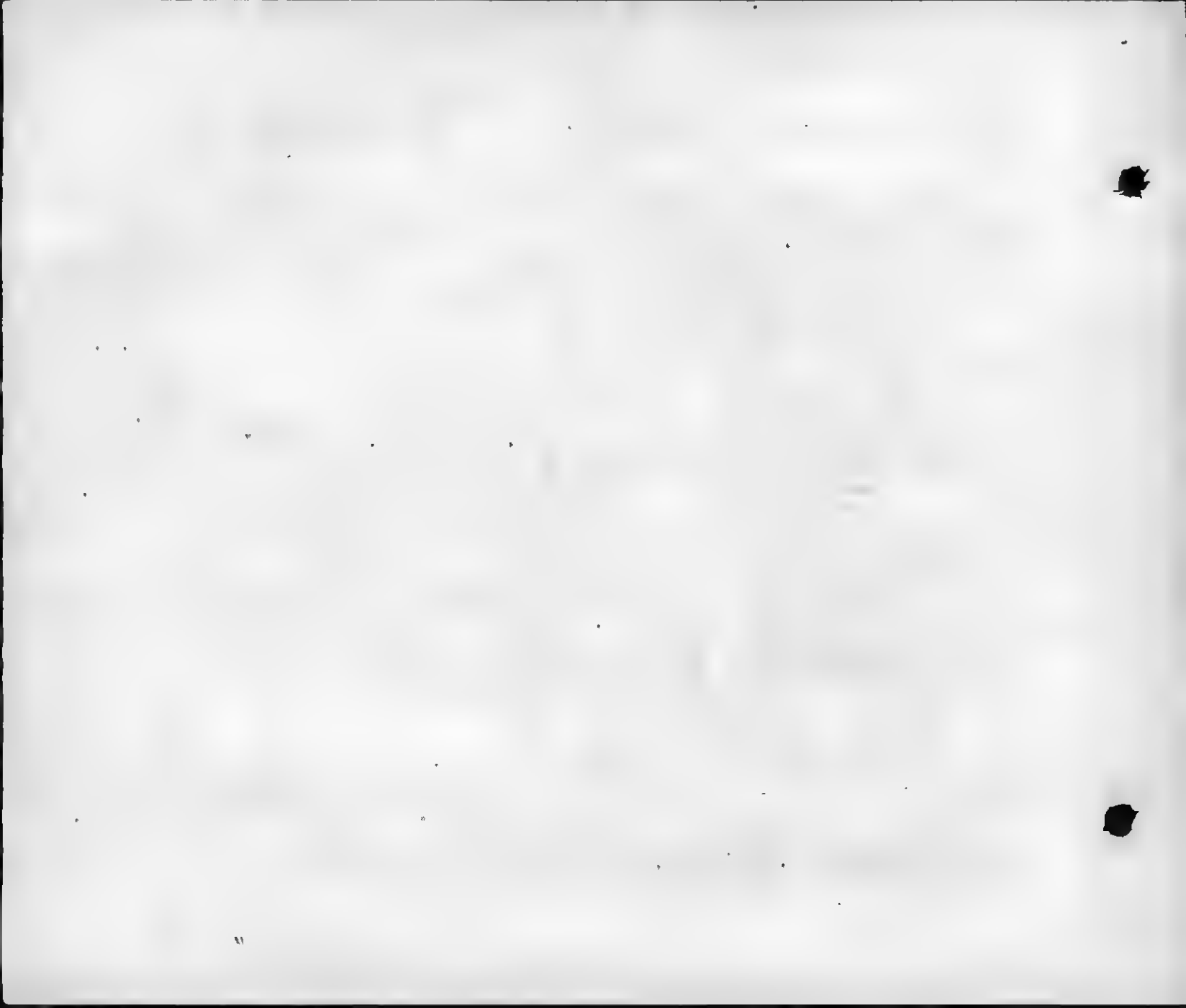
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Freehold, N.J.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		-Glen Burnie, Md. 67x-	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Plaza Manor Nursing Home		d. STREET ADDRESS		Glen Burnie, Maryland	
3. NAME OF DECEASED (Type or print)		Annie B. Gregory		4. DATE OF DEATH		October 31, 1959	
5. SEX		Female		6. COLOR OR RACE		N	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		Unknown	
9. AGE (In years last birthday)		84 yrs		10. IF UNDER 1 YEAR		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Trained Nurse		Medical		Stanton, Virginia		U.S.A.	
13. FATHER'S NAME		Unknown		14. MOTHER'S MAIDEN NAME		Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Ave.	
No		None		Mrs. Gladys J. Hawkins-1532 Druid Hill			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH		? yrs.	
450.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) DUE TO		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Senile Psychosis, Glaucoma.		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
Hour o. m. p. m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
21. I certify that I attended the deceased from August 8, 1959, to October 31, 1959, that I last saw the deceased alive on October 24, 1959, and that death occurred at 8:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE		James M. Pair		ADDRESS (Street, city or town, state)		DATE SIGNED	
James M. Pair, M.D.		400 N. Carrollton Avenue Balto.		23.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
Burial		Nov 4, 1959		Mt. Auburn		Cambridge, Mass	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Holland Funeral Home		Thornton White		DATE			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)  
15M 9/55



10929

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>A.A.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>203 Gloucester St.</b>				d. STREET ADDRESS <b>203 Gloucester St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>APHRODITE</b> First Middle Last				4. DATE OF DEATH <b>HALAKUS</b> Month <b>10</b> Day <b>7</b> Year <b>1959</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Unknown</b>	
9. AGE (In years last birthday) <b>about 18</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>GREECE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>GREECE</b>							
13. FATHER'S NAME <b>PETER VOSINAS</b>				14. MOTHER'S MAIDEN NAME <b>K. ROSOKIS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <b>—</b>			
17. INFORMANT <b>MRS. THEODORE G. NICHOLS</b> Address <b>#2</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446x</b> <b>Azotemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Arteriosclerosis Generalized</b> DUE TO (c) <b>Chronic Nephritis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 Wk.</b> <b>4 yrs.</b> <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>June 15</b> , 1950, to <b>Oct. 7</b> , 1959, that I last saw the deceased alive on <b>10-7</b> , 1959, and that death occurred at <b>7:15</b> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>James R. Martin</b> M.D.				<b>6 SHAW ST</b> <b>10-9-59</b>			
PHYSICIAN'S NAME (Type) <b>JAMES R. MARTIN</b>				<b>ANNAPOLIS, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>10-9-59</b>		<b>ST. JAMES</b>		<b>ANNAPOLIS MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Lefterious</b> ADDRESS <b>Annepolis, Md.</b>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <b>OCT 13 '59</b>		<b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Item 7 File G249 10-2-59 et

# CERTIFICATE OF DEATH

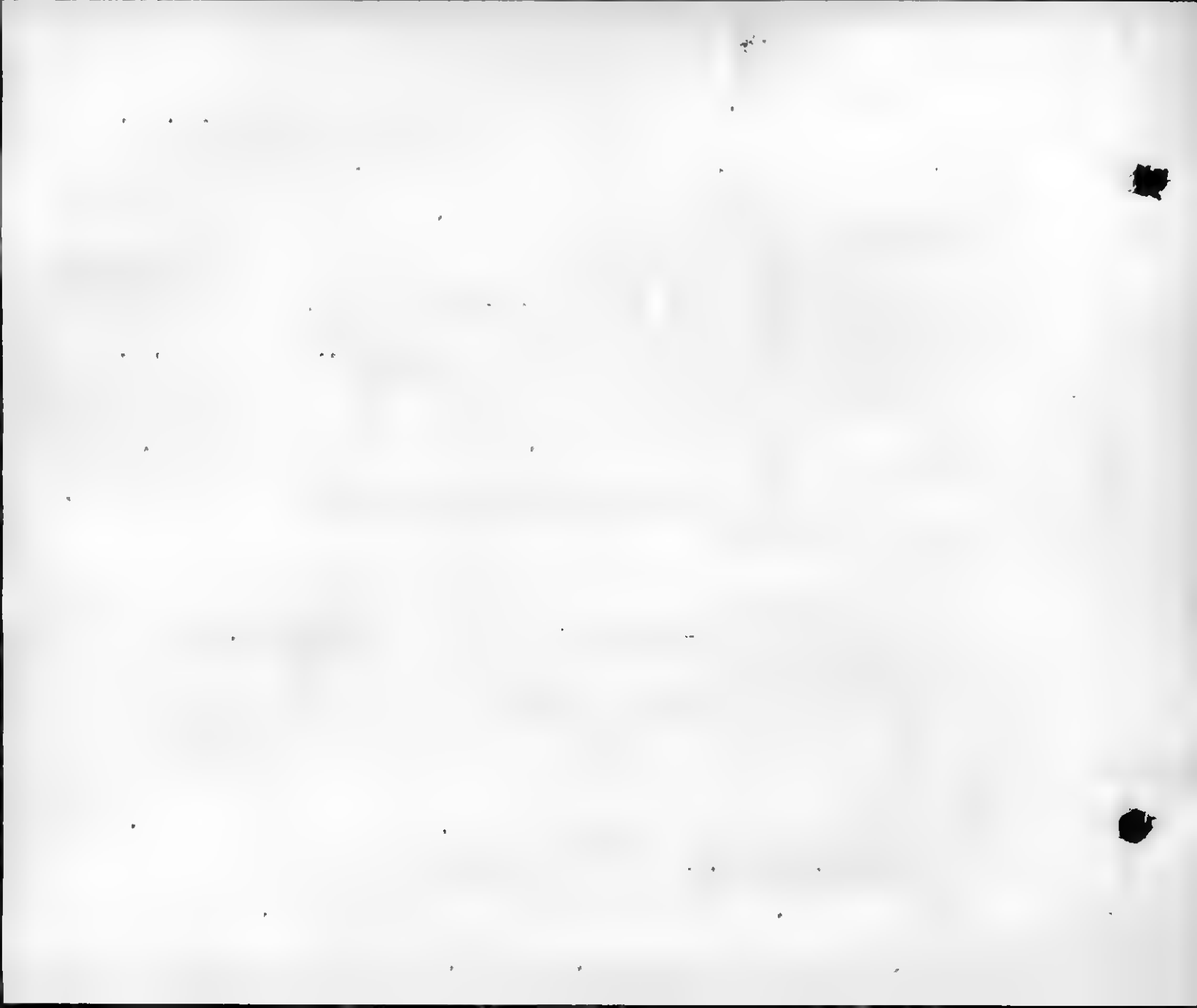
10934

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel Co.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A. A. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Glen Burnie, Md.</b>		c. LENGTH OF STAY IN 1b <b>2014</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>		d. STREET ADDRESS <b>3022 W. North Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Mamie</b> Middle <b>Mary</b> Last <b>Hall</b>		4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-18-1889</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>St Mary's Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Henry Cole</b>		14. MOTHER'S MAIDEN NAME <b>Lionell Cole</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. ADDRESS <b>Mrs. Juanita Brown 2723 Parkwood Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Paralysis agitans; osteo-arthritis fingers, old fracture r. femur</b>			
19. INTERVAL BETWEEN ONSET AND DEATH <b>? yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 9, 1959</b> , to <b>October 3, 1959</b> that I last saw the deceased alive on <b>September 26, 1959</b> and that death occurred at <b>9:30 M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>400 N. Carrollton Avenue</b> DATE SIGNED <b>Oct. 5, 1959</b>			
ACTUAL SIGNATURE <b>James M. Pair</b> M.D. <b>James M. Pair, M.D.</b> <b>Baltimore 23, Maryland</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
22b. DATE THEREOF <b>Oct. 8, 1959</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>			
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>William A. Jackson Funeral Home Inc. Penna Ave.</b>			
ADDRESS <b>916</b>			
24a. REC'D BY REGISTRAR <b>DATE OCT 6 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Orline S. Thomas</b>			

**TO HOSPITAL OF ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4

VE A15 (4)  
ISM 9/SB



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10979

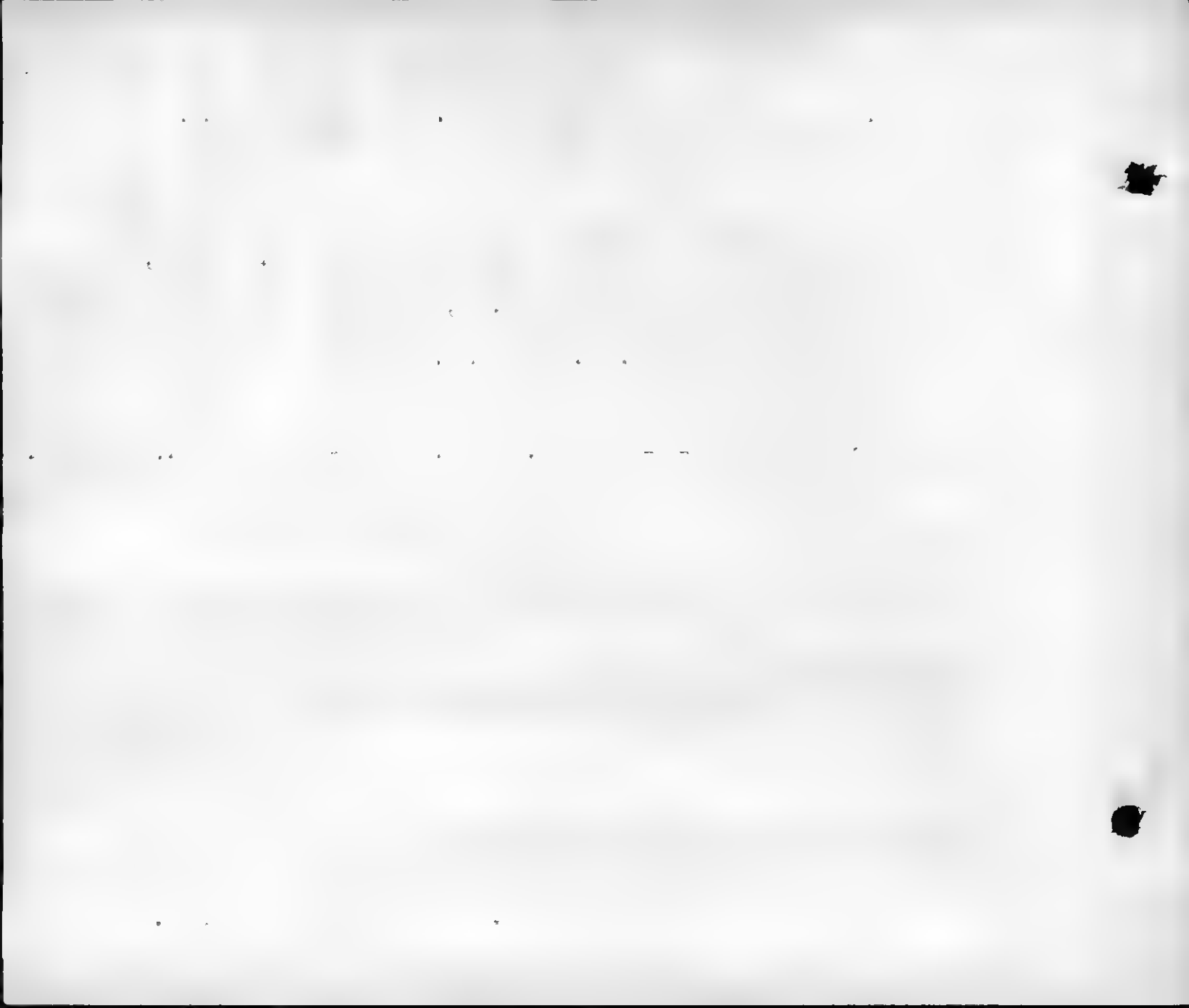
## CERTIFICATE OF DEATH

10935

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>A. A.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severna Park</b>		c. LENGTH OF STAY IN 1b <b>X Severna Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>111 Hatton Drive</b>		d. STREET ADDRESS <b>111 Hatton Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>FREDERICK</b> Last <b>HARMER</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>12,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12, 1896</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min.	11. IF UNDER 24 HRS Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bell Tel. Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>N. J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>N. J.</b>	
13. FATHER'S NAME <b>William Harmer</b>		14. MOTHER'S MAIDEN NAME <b>Julia B. Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>yes World War 1</b>		16. SOCIAL SECURITY NO. <b>164-05-9624</b>	
17. INFORMANT <b>Dr. Jene D. Trettin-111 Hatton Dr., Severna Pk.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>199.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary edema</b> (c) <b>Carcinoma of</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>72 hrs</b> <b>8 mrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 May</b> , 19 <b>59</b> , to <b>12 Oct</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12 Oct</b> , 19 <b>59</b> , and that death occurred at <b>5:40 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gene D. Trettin</b>		ADDRESS (Street, city or town, state) <b>M.D. 111 HATTON DR. SEVERNAPARK, MD</b>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <b>12 Oct 59</b>	
22a. BURIAL, CREMAT. OR REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>10/13/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Drexel Hill, Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kneass</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	
24a. REC'D BY REGISTRAR <b>OCT 13 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

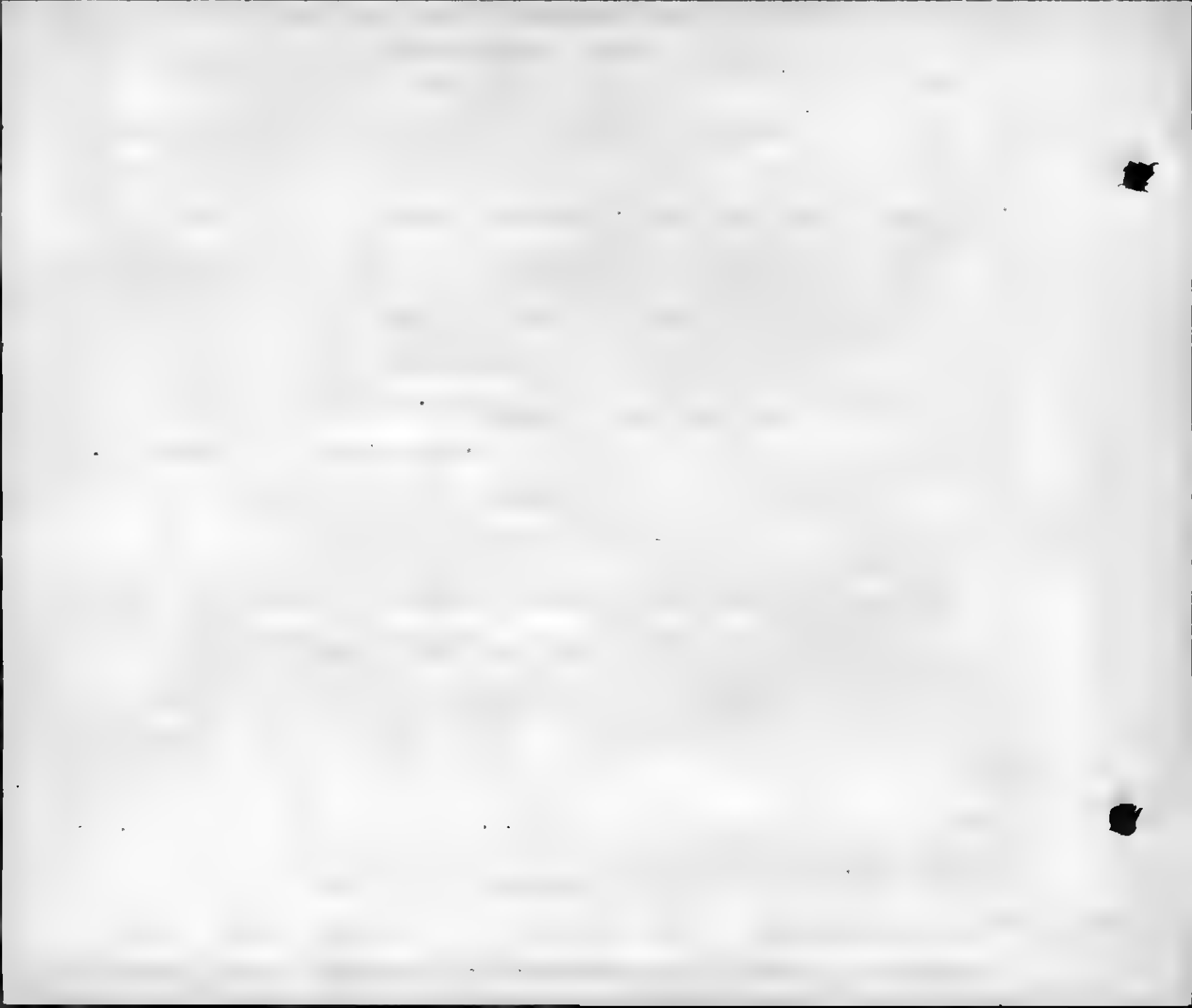
10930

## CERTIFICATE OF DEATH

10936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</u>				e. STREET ADDRESS <u>411 Jefferson</u>			
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>(n)</u> Last <u>HEADLICKS</u>				4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 May 1939</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John W. Ford</u>				14. MOTHER'S MAIDEN NAME <u>Annie F. Bull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Odell J. Payseur</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11</u> p. m. <u>59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11 October</u> , 19 <u>59</u> , to <u>12 October</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11 October</u> , 19 <u>59</u> , and that death occurred at <u>1:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</u> DATE SIGNED <u>10-12-59</u>							
ACTUAL SIGNATURE <u>R. C. Laiting</u>				M.D. <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</u>			
PHYSICIAN'S NAME (Type) <u>R. C. LAITING MD USN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN TAYLOR &amp; SONS</u>				ADDRESS <u>Duke &amp; Gloucester</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>CW P. H.</u>							



10931

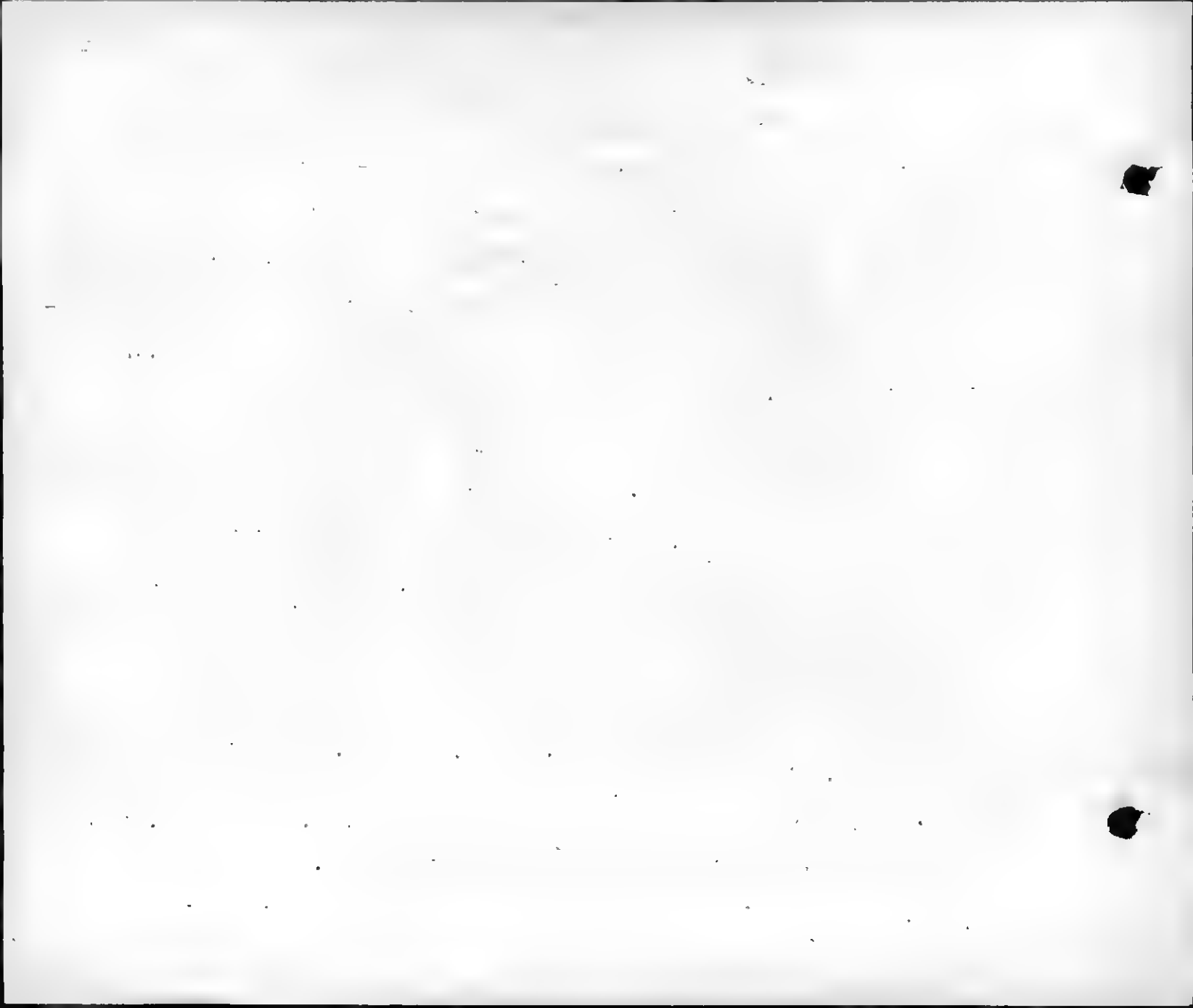
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>2 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>201 Dreams Landing</b>	
3. NAME OF DECEASED (Type or print) First <b>Unnamed</b> Middle <b>HOCKENBERRY</b> Last <b>HOCKENBERRY</b>		4. DATE OF DEATH Month <b>October</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 29, 1959</b>
9. AGE (In years last birthday) yrs. <b>2</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert Owen HOCKENBERRY</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Jean POWERS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>[ ]</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>761.0</b> DUE TO <b>Cardio respiratory failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Premature labor &amp; delivery</b> DUE TO <b>Premature Separation low in placenta</b> (c) <b>[ ]</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>[ ]</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>[ ]</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 29, 1959</b> to <b>Oct. 30, 1959</b> , that I last saw the deceased alive on <b>Oct. 30, 1959</b> , and that death occurred at <b>1:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stuart M. Christhilf</b>		ADDRESS (Street, city or town, state) <b>69 Franklin St., Annapolis, Md.</b> DATE SIGNED <b>10/30/59</b>	
PHYSICIAN'S NAME (Type) <b>Stuart M. Christhilf</b> <b>Annapolis, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>11-2-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cemet., Annapolis, Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Happy</b> ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 4 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Christ &amp; Thoma</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10932

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Gambrills</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>110 Clay St.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Thomas</b>		First <b>Thomas</b>		Middle <b>HOWARD</b>	
Last <b>HOWARD</b>		4. DATE OF DEATH <b>October 18 1959</b>		Month <b>October</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>7-23-1920</b>		9. AGE (In years last birthday) <b>39 yrs.</b>		10. IF UNDER 1 YEAR Months <b>39</b>	
11. IF UNDER 24 HRS Days <b>39</b>		12. IF UNDER 24 HRS Hours <b>39</b>		13. IF UNDER 24 HRS Min. <b>39</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Richard Howard</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Moreland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-18-5873</b>		17. INFORMANT <b>Richard Howard Gambrills Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffered from Phosphorus</b> <b>600.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Secondary Hematogenous</b> DUE TO (c) <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>600.0</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Contributing to death</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>110 Clay St.,</b>		(County) <b>Annapolis, Md.</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Oct 17, 1959</b> , to <b>Oct 18, 1959</b> , that I last saw the deceased alive on <b>Oct 18, 1959</b> , and that death occurred at <b>12:35 A.M.</b> , from the causes and on the date stated above		ADDRESS (Street, city or town, state) <b>110 Clay St.,</b>		DATE SIGNED <b>10/19/59</b>	
ACTUAL SIGNATURE <b>R. L. Richardson</b>		M.D. <b>Ann Arbor, Mich.</b>			
PHYSICIAN'S NAME (Type) <b>R. L. Richardson</b>		Ann Arbor, Mich.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 10-21-59</b>		22b. DATE THEREOF <b>10-21-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wilson Memorial</b>	
22d. LOCATION (City, town, or county) <b>Gambrills Md.</b>		(State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Keese</b>		ADDRESS <b>#108 Wash St. Annapolis Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. Thomas</b>					

VS A15 (4)  
ISM 9/SB



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10980**  
**CERTIFICATE OF DEATH**

**10939**

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float:right"><b>MARYLAND</b></span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived: If institution Residence before admission) a. STATE <u>Maryland</u> <span style="float:right">b. COUNTY <u>Wicomico</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b <u>10mo. 14 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>219 E. Church</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float:right">First Middle Last</span> <u>Saunders Hutt</u>				<b>4. DATE OF DEATH</b> Month <u>10</u> Day <u>18</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/13/1882</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u>		IF UNDER 24 HRS Hours <u>7</u> Min. <u>7</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hutt</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Bishop</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT <u>Hospital Records</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446x</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost } (b) <u>Nephrosclerosis</u> (c) <u>Generalized and Cerebral Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to Cerebral Arteriosclerosis-Inguinal Hernia</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>-----</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>9:30</u> p. m. <u>19 59</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Non-white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State) <u>-----</u>	
21. I certify that I attended the deceased from <u>12/14</u> 19 <u>58</u> , to <u>10/18</u> 19 <u>59</u> , that I last saw the deceased alive on <u>10/18</u> 19 <u>59</u> and that death occurred at <u>11:05</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lionel McHenry Mapp, M.D.</u>				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>10/19/59</u>			
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>				<u>Crownsville State Hospital, Md.</u> <u>10/19/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clifton S. Stewart</u>				ADDRESS <u>Salisbury Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 26 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

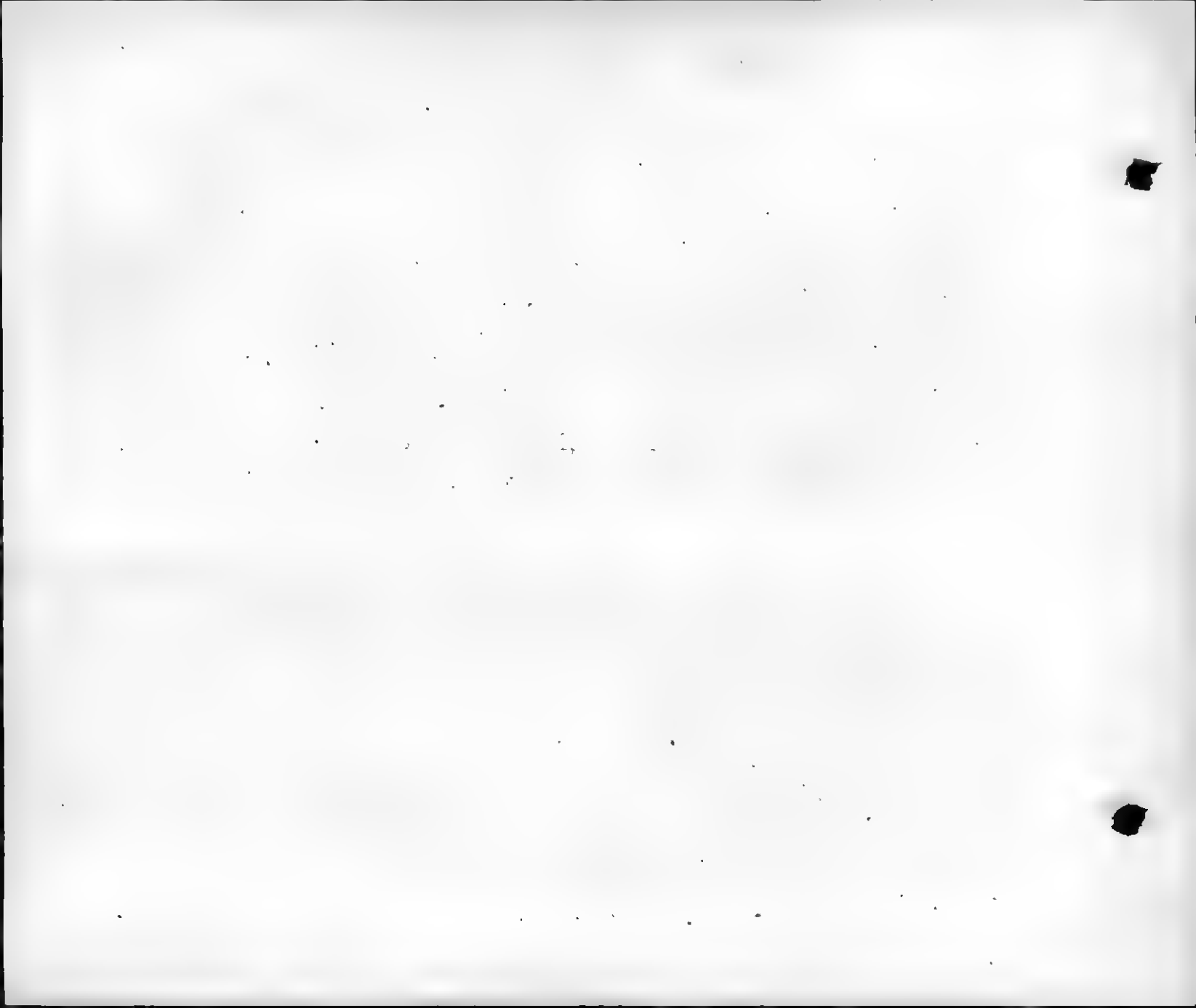
10933

1. PLACE OF DEATH a. COUNTY <u>1. A</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>MD</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>13 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>817 Spa Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rachel</u> Middle <u>Ireland</u> Last <u>10</u>		4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 3 - 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>SALLIE MCGOWANS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>NONE</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>590X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>auto glomerulonephritis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-26-59</u> , 19 <u>59</u> , to <u>10-6-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-4-59</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>62 Chestnut St</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		DATE SIGNED <u>10-6-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-9-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer-Hill</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks III</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>	
ADDRESS <u>ANNAPOLIS - MD</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10981

## CERTIFICATE OF DEATH

10941

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phys. Home</i>				d. STREET ADDRESS <i>10000 R. Annie Branch Rd.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Robert</i> Middle <i>H. L.</i> Last <i>Jackson</i>				4. DATE OF DEATH Month <i>10</i> Day <i>10</i> Year <i>1959</i>			
5. SEX <i>M.</i>	6. COLOR OR RACE <i>C.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 1871</i>	9. AGE (In years last birthday) <i>88</i> yrs.	IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min <i>—</i>	IF UNDER 24 HRS Hours <i>—</i> Min <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clock Store</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>ret.</i>		11. BIRTH PLACE (State or foreign country) <i>U.S.A. (Virginia)</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert L. Jackson</i>				14. MOTHER'S MAIDEN NAME <i>India Collins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Glenn Jackson</i> Address <i>10321 1st St. Baltimore</i>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b) and (c)} PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>pericardial thrombosis -</i> <i>422.1</i> DUE TO <i>arteriosclerotic cardiac -</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>coronary atherosclerosis &amp; heart failure</i> DUE TO (c) <i>myocardial infarction</i>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>no</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>—</i> p. m. <i>—</i> 19 <i>59</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>no</i>	
				20f. (City or town) <i>no</i>		(County) (State)	
21. I certify that I attended the deceased from <i>10/18</i> 19 <i>59</i> to <i>10/10</i> 19 <i>59</i> , that I last saw the deceased alive on <i>10/9</i> 19 <i>59</i> , and that death occurred at <i>12:30</i> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Fielder P. P. P.</i>				ADDRESS (Street, city or town, state) <i>P.O. Box 97 Odenton</i>			
DATE SIGNED <i>10/10/59</i>							
PHYSICIAN'S NAME (Type) <i>Fielder P. P. P.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE, THEREOF <i>10/11/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Blue Bell, W.D.</i>		22d. LOCATION (City, town, or county) (State) <i>Care Grove</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>HOLLAND FUNERAL HOME - 1631 DRUID HILL</i>				ADDRESS <i>17th Ave</i>		24a. REC'D BY REGISTRAR <i>DATE OCT 13 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Carlton E. Jones</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

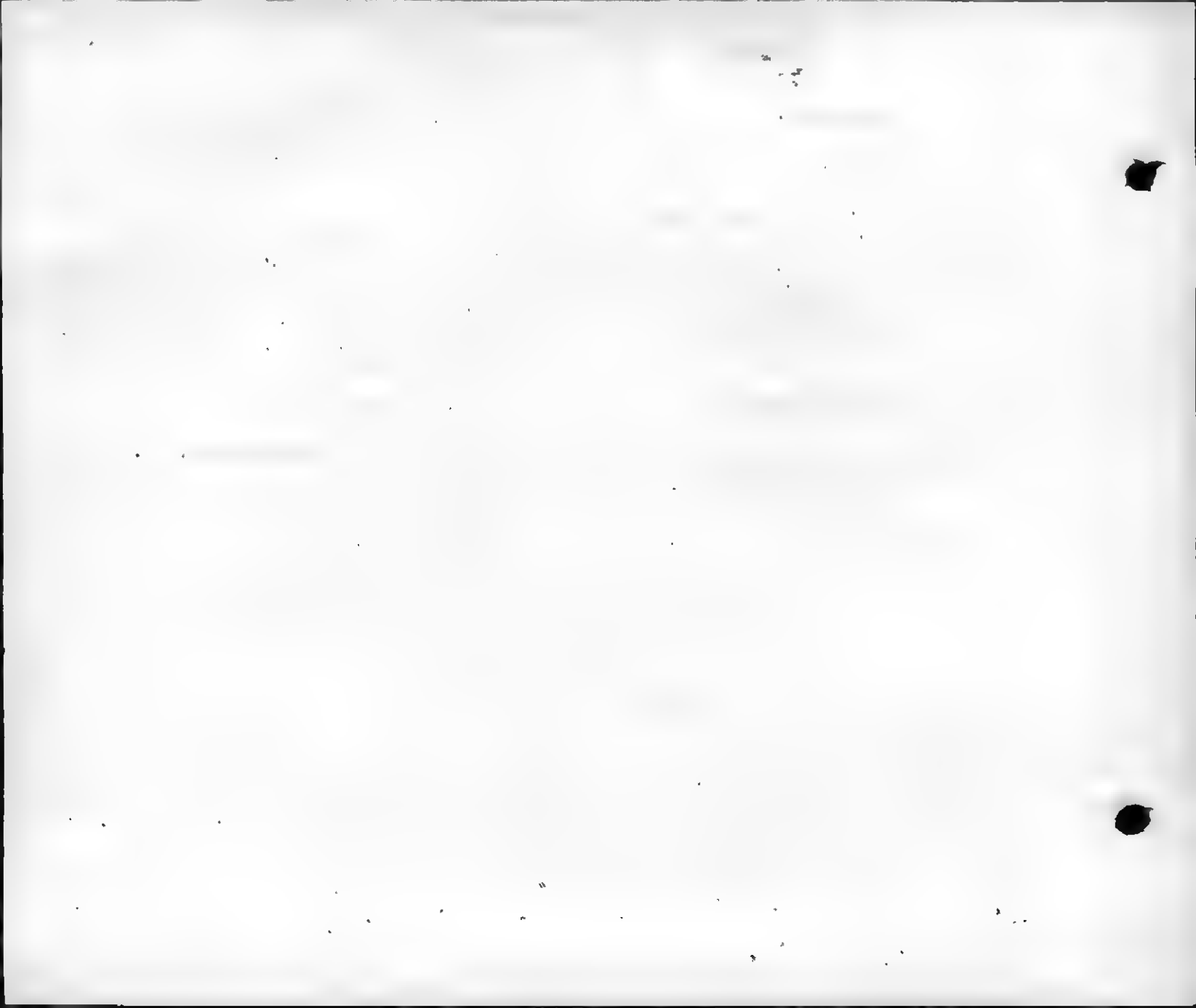
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10934 CERTIFICATE OF DEATH

10942

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>103</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Ad. County</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumbersstone Md.</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby</b> First Middle Last 4. DATE OF DEATH Month Day Year <b>October 22 1959</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>Negro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> B. DATE OF BIRTH <b>October 22, 1959</b> 9. AGE (In years last birthday) yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Richard Johnson</b> 14. MOTHER'S MAIDEN NAME <b>Alice Marie Edwards</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. INFORMANT <b>Mother</b> Address <b>Cumbersstone, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral birth injury</b> 76.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Asphyxia consequent to maternal hemorrhage</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None other</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>22 Oct</b> , 19 <b>59</b> , to <b>22 Oct</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>22 Oct</b> , 19 <b>59</b> , and that death occurred at <b>2:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>121 Cathedral St Annapolis 230559</b>			
ACTUAL SIGNATURE <b>J. L. Swalk</b> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>10-26-59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Hopse Chapel</b> 22d. LOCATION (City, town, or county) (State) <b>Edgewater Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese #108 Wash St. Annapolis</b> ADDRESS 24a. REC'D BY REGISTRAR DATE <b>OCT 29 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

50-2299XUS



## CERTIFICATE OF DEATH

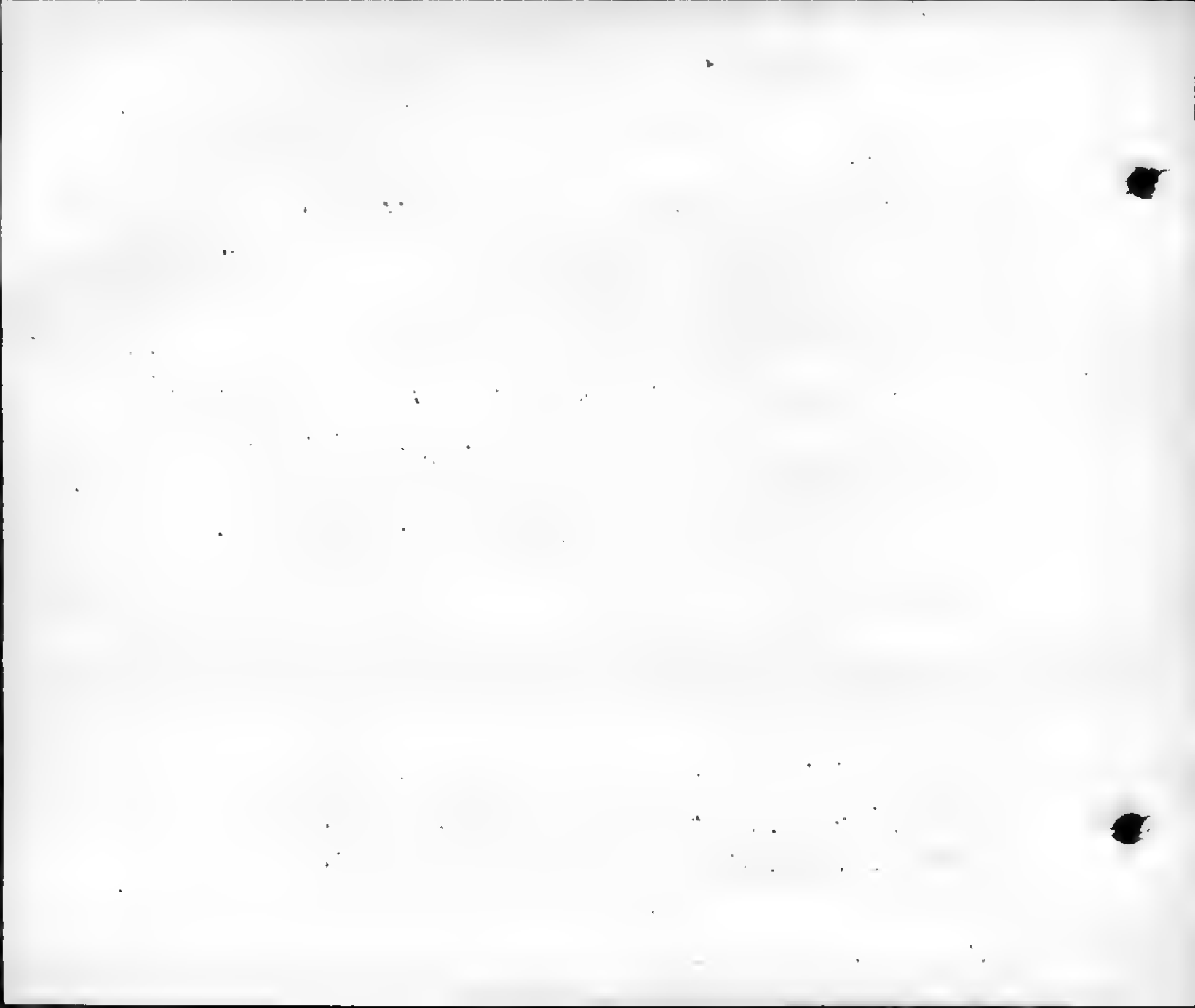
Reg. Dist. No.

10935

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>34 Pinkney St.,</b>	
3. NAME OF DECEASED (Type or print) First <b>Adella</b> Middle <b>JOHNSON</b> Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>October</b> Day <b>16</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1908</b>
9. AGE (In years last birthday) yrs. <b>51</b>		10. IF UNDER 1 YEAR: Months <b></b> Days <b></b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Actwood</b>		14. MOTHER'S MAIDEN NAME <b>Florence Colbert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Jerome Johnson 34 Pinkney St.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>44.21</b> DUE TO <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiac Disease - Chronic</b> DUE TO <b>Stroke</b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
19a. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20b. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 13, 19 59</b> to <b>Oct 16, 19 59</b> , that I last saw the deceased alive on <b>Oct 16, 19 59</b> , and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Therese H. Johnson</b> M.D.		ADDRESS (Street, city or town, state) <b>37 Calvert St.,</b> DATE SIGNED <b></b>	
PHYSICIAN'S NAME (Type) <b>T. H. Johnson</b>		<b>Annapolis, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-19-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hall</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese #108 Wash St Annapolis</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 19 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Kinn</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

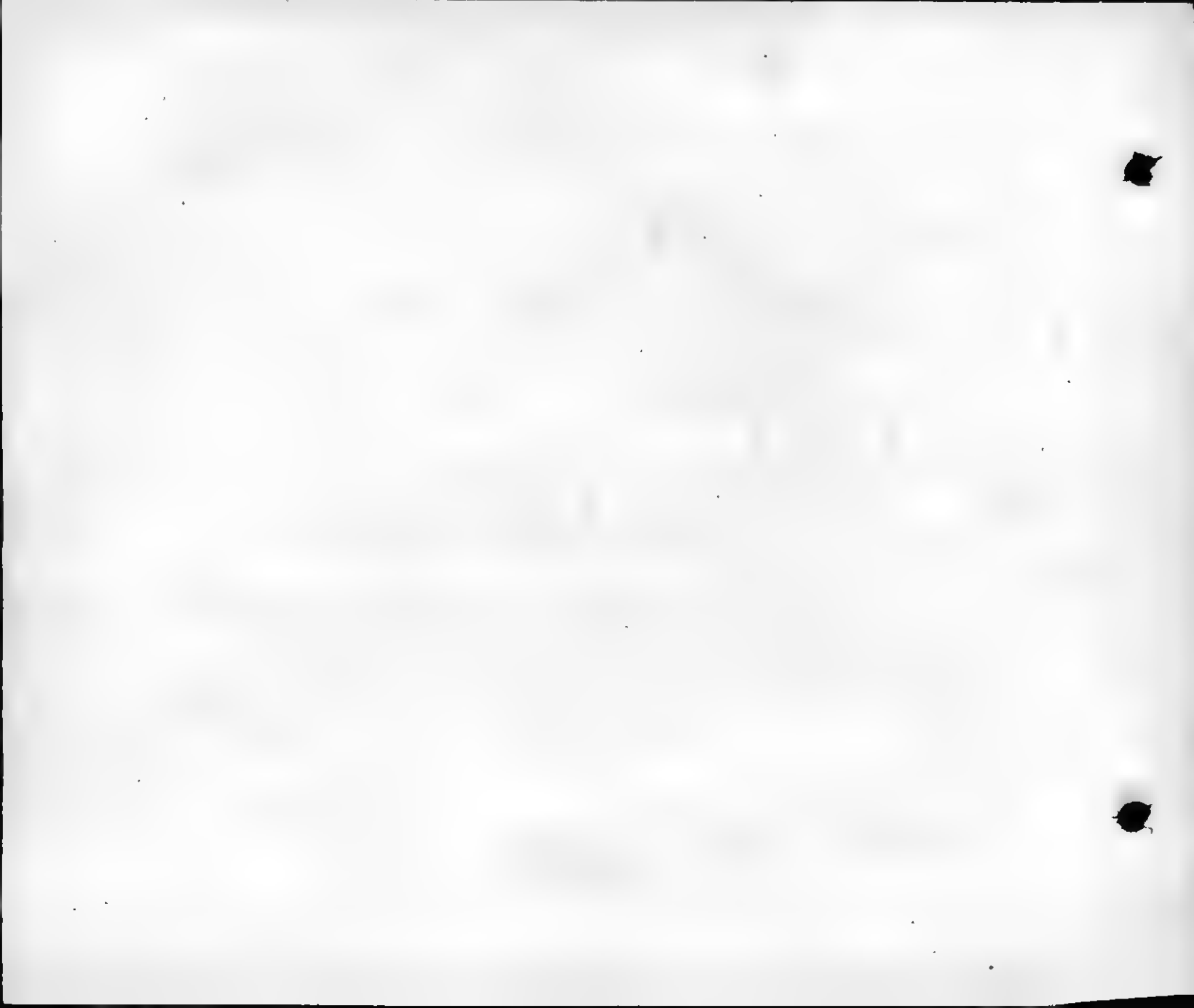


10982

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>md</i> b. COUNTY <i>a a</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Ann's Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>James Johnson</i>		4. DATE OF DEATH <i>10/5/59</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 14<sup>th</sup> 1892</i>
9. AGE (In years last birthday) <i>67</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Slavin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>Yes</i> (If yes, give war or dates of service) <i>World War I</i>		16. SOCIAL SECURITY NO <i>Min James F. Remball</i>	
17. CAUSE OF DEATH [Enter only one cause per 17a for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Arteriosclerosis</i> DUE TO <i>Rheumatoid arthritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO <i></i> (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Seriously</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9/30/59</i> , that I last saw the deceased alive on <i>10/3/59</i> , and that death occurred at <i>11:45 P.M.</i> from the causes and on the date stated above.		21. ADDRESS (Street, city or town, state) <i>10/5/59</i>	
21. ACTUAL SIGNATURE <i>Joseph Lipskey M.D.</i>		21. DATE SIGNED <i>10/5/59</i>	
21. PHYSICIAN'S NAME (Type) <i>JOSEPH LIPSKEY</i>			
22a. DATE OF CREMATION, REMOVAL (Specify) <i>Oct 8-59</i>		22b. NAME OF CEMETERY OR CREMATORY <i>St Marys</i>	
22c. LOCATION (City, town, or county) <i>Annapolis Md</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		24a. REC'D BY REGISTRAR <i>Carthur L. Hume</i>	
24b. REGISTRAR'S SIGNATURE		DATE <i>OCT 9 '59</i>	



10936

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>27 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
f. STREET ADDRESS <u>1448 N. Carey Street</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sylvester</u> Middle <u>JOHNSON</u> Last <u>JOHNSON</u>				4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/5/21</u>	9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months <u>38</u> Days <u>38</u> Hours <u>38</u> Min <u>38</u>	IF UNDER 24 HRS Hours <u>38</u> Min <u>38</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer- Gardener</u>				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Perry Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Susie Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1/13/43-7/30/43</u> <u>Unknown</u>				16. SOCIAL SECURITY NO <u>Unknown</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia Terminal</u> <u>134.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Meningitis (Cryptococcosis)</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----			
20c. TIME OF INJURY Month. Day. Year Hour a. m. ----- 19 p. m. -----				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) -----				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9/24</u> , 19 <u>59</u> , to <u>10/21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/21</u> , 19 <u>59</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Hildegard Heard Reissman</u> M.D.				<u>Crownsville State Hospital, Md.</u> <u>10/21/59</u>			
PHYSICIAN'S NAME (Type)				<u>Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md.</u> <u>10/21/59</u>			
22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-26-59</u>		<u>Baltimore</u>		<u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Singley Nelson</u>				24a. REG'D BY REGISTRAR <u>1348 N. Calhoun St</u> <u>OCT 26 59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Lawrence

(212 000 000 000 000)

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10946

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director or, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

1. PLACE OF DEATH a. COUNTY <u>Prince George's County</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's County</u>		
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b <u>1966</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Admiral Hospital</u>			e. STREET ADDRESS <u>1966 West Street</u>		
3. NAME OF DECEASED (Type or print) <u>Alphonsa</u> First <u>Jones</u> Middle Last			4. DATE OF DEATH Month <u>10</u> - Day <u>19</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-14-1959</u>	9. AGE (In years last birthday) yrs <u>3</u>	10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Willie Jones</u>			14. MOTHER'S MAIDEN NAME <u>Roberta A. Lee</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>Robert A. Lee 1966 West Street</u>		
17. INFORMANT <u>Robert A. Lee</u>			Address <u>1966 West Street</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Disease</u> 4544 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Under</u> (a), stating the underlying cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>E. Linhardt</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>E. Linhardt</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-22-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keese</u>			24a. REC'D BY REGISTRAR <u>23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

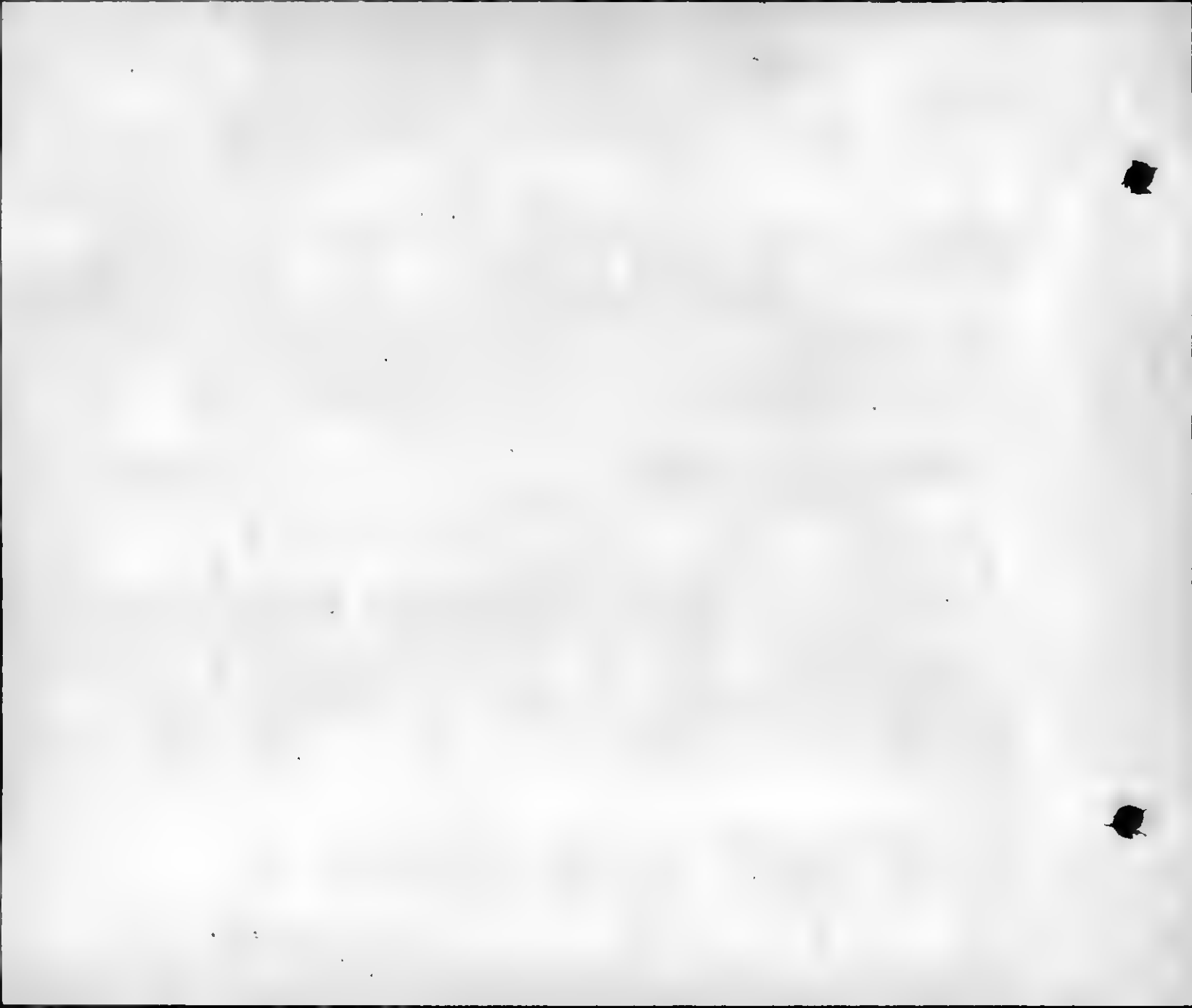
10947

Reg. Dist. No.

10983

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>✓</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>2 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 11</u> <span style="float: right;">3 V 1-1</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Moose Hall, S. Cain Highway</u>				d. STREET ADDRESS <u>1016 W. 38th Street,</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Brice</u> <span style="float: right;">First</span> <u>A. Keys</u> <span style="float: right;">Middle</span> <span style="float: right;">Last</span>				<b>4. DATE OF DEATH</b> <span style="float: right;">Month</span> <u>October</u> <span style="float: right;">Day</span> <u>25th</u> <span style="float: right;">Year</span> <u>19 59</u>			
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>5/2/13</u>			
<b>9. AGE</b> (In years last birthday) <u>46</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Maintenance man at Eastern Box Co.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Baltimore, Md.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>James W. Keys</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Florence Stambaugh.</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> <span style="float: right;">Address</span> <u>Mr. Leroy I. Keys (brother)</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Coronary Occlusion</u>  <div style="margin-top: 10px;"> <b>DUE TO</b>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <span style="float: right;">(b)</span> <u>  </u>  <b>DUE TO</b> <span style="float: right;">(c) <u>  </u> </span></div> </div> <div style="width: 15%; text-align: center;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>Sudden</u> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> <span style="float: right;">Month, Day, Year</span> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u> <span style="float: right;">(County)</span> <u>  </u> <span style="float: right;">(State)</span> <u>  </u>		<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
<b>ACTUAL SIGNATURE</b> <u>Gustave H. Faubert, M.D.</u> <span style="float: right;">M.D.</span>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>10/25/59</u>			
<b>EXAMINER'S NAME (Type)</b> <u>Gustave H. Faubert, M.D.</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>10/29/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Ponlar</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Balto Co. Md.</u>		<b>22e. (State)</b> <u>  </u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Cecilia E. Donovan - 3818 Polang Ave</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE OCT 27 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kneass</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

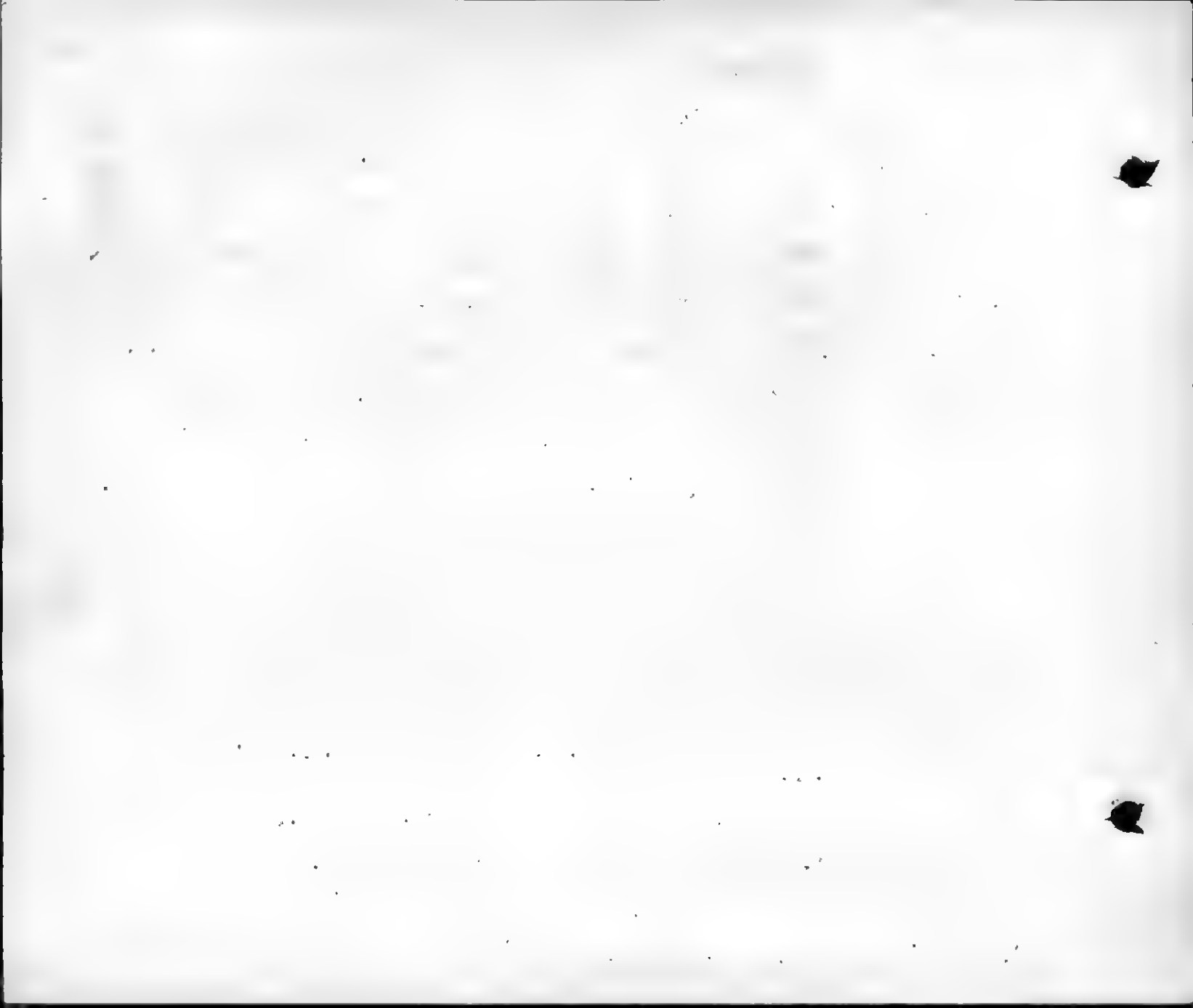
CERTIFICATE OF DEATH

Reg. Dist. No. 10948

10938

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Res. dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>506 Pafel Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Lula</b> Middle <b>SKINNER</b> Last <b>KOLBE</b>		4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>1959</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 2, 1901</b>
9. AGE (In years lost birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min <b>58</b>	IF UNDER 24 HRS Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>HENRY T. MILLER</b>	
14. MOTHER'S MAIDEN NAME <b>MARTHA E. BOUSH</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>MRS. ERNEST W. ROBY #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute pulmonary edema</b> <b>422.1</b> DUE TO (b) <b>arteriosclerosis CVD</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>ARTERIOSCLEROSIS</b> DUE TO (c) <b>ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 3, 1959</b> , to <b>Oct. 3, 1959</b> that I last saw the deceased alive on <b>Oct. 3, 1959</b> , and that death occurred at <b>1:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank M. Shipley</b> M.D.		ADDRESS (Street, city or town, state) <b>121 Cathedral St.,</b> DATE SIGNED <b>10/5/59</b>	
PHYSICIAN'S NAME (Type) <b>Frank M. Shipley</b>		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10-4-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR BLUFF</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. G. &amp; Sons</b> ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 7 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

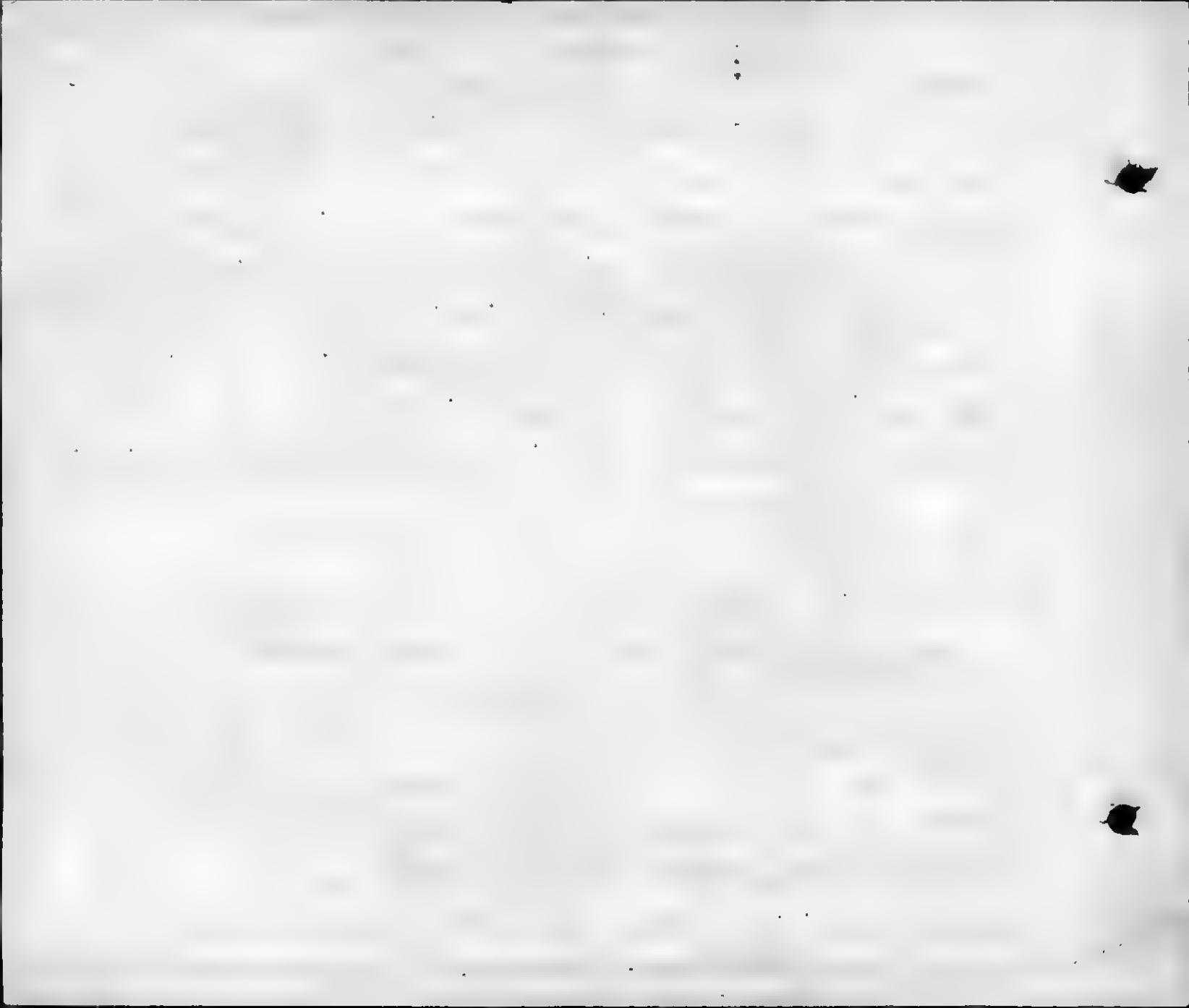
10949

10984

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farland Park Ferndale</u>			
c. LENGTH OF STAY IN 1b <u>1 life</u>				d. STREET ADDRESS <u>103 Elm Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>M.</u> Last <u>Krieger</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 17, 1887</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Vettters</u>				14. MOTHER'S MAIDEN NAME <u>Ida V. Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Am. Frederick Krieger-Son-Balto. Id.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>accident chronic</u> DUE TO <u>the accident at the 1st afternoon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 1954</u> , to <u>10-31</u> , 1959, that I last saw the deceased alive on <u>10-31</u> , 1959, and that death occurred at <u>7:40 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eugene Schnitzer, M.D.</u>				ADDRESS (Street, city or town, state) <u>3904 S. HANOVER ST. BALTIMORE 25, MD.</u>			
PHYSICIAN'S NAME (Type) <u>Eugene Schnitzer, M.D.</u>				DATE SIGNED <u>11-2-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 3, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ritchie Highway Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HERMAN FUNERAL HOME</u>				ADDRESS <u>1216 S. Charles St.</u>		24a. REC'D BY REGISTRAR <u>DATE NOV 5 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

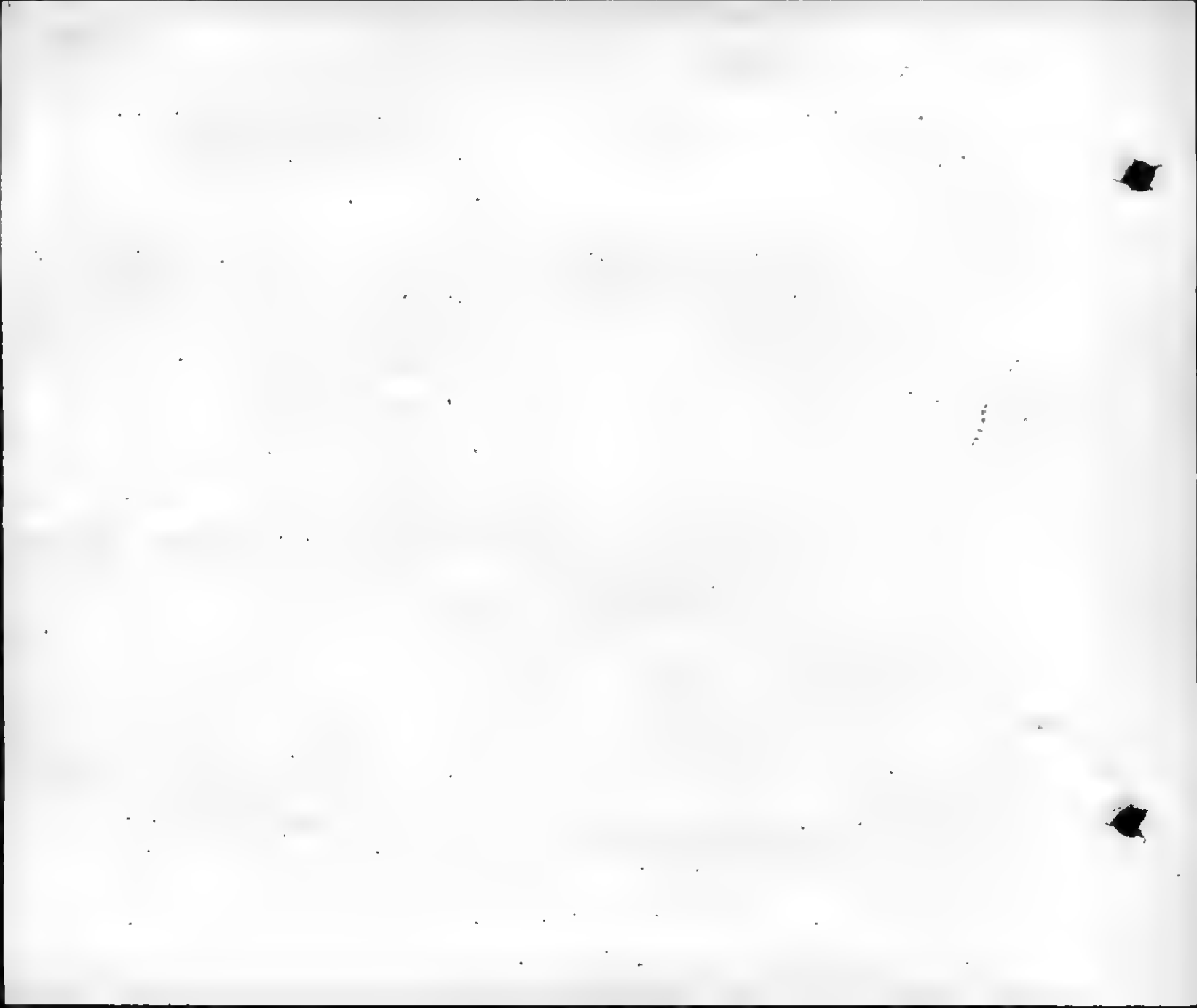
10985

CERTIFICATE OF DEATH

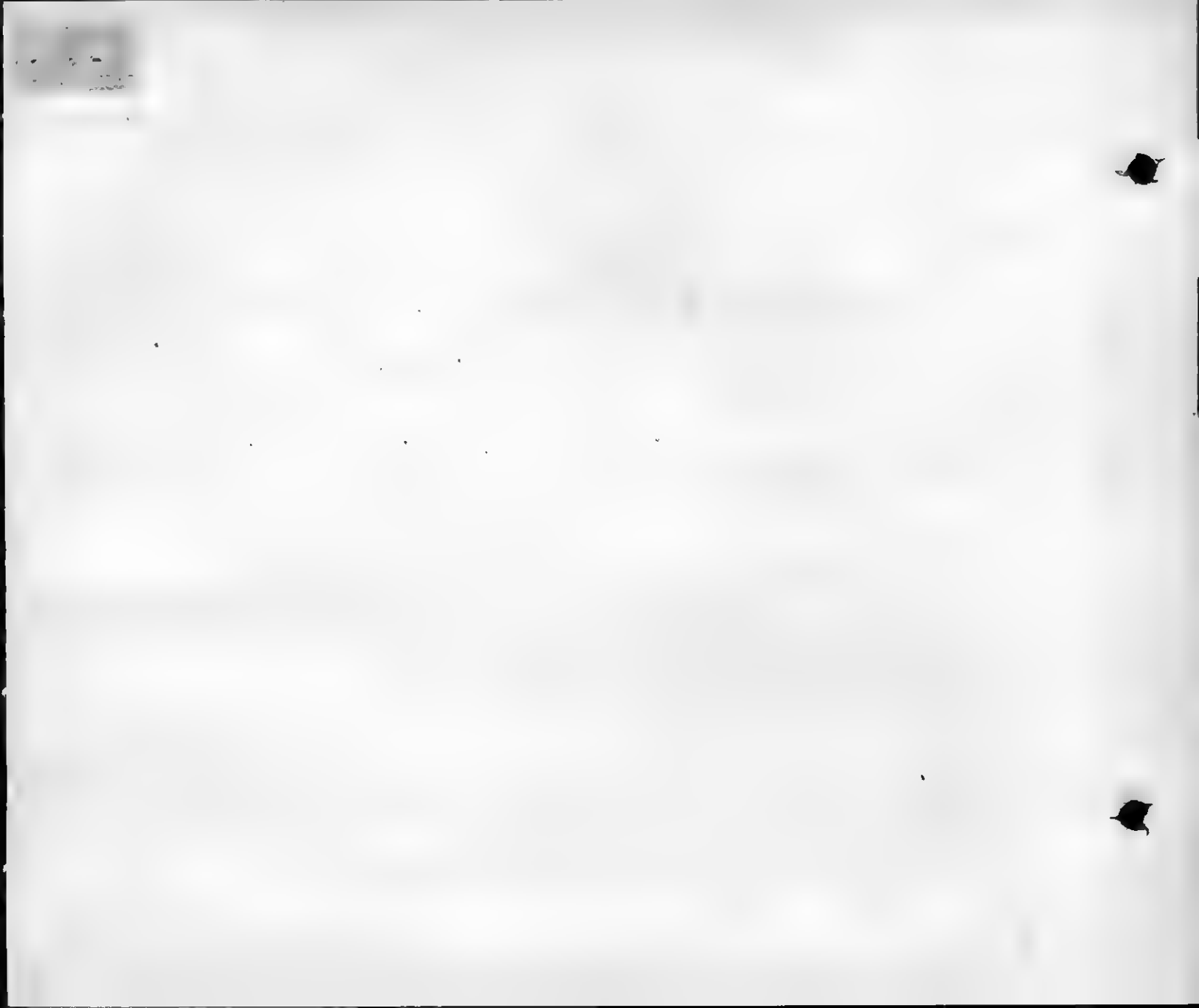
Reg. Dist. No.

10950

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn (Rural)</u>		c. LENGTH OF STAY IN Tb <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn (Rural)</u>		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 2, Box 95</u>				d. STREET ADDRESS <u>Route 2, Box 95</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Roberta</u> Last <u>Loving</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 13, 1884</u>	9. AGE (in years last birthday) yrs. <u>75</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Clark</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Griffith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u></u>		INFORMANT <u>Ruth M. Loving</u> Address <u>Same as 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260 X Cardio-Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis + Hypertension</u> DUE TO (c) <u>Diabetes -</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5-6 yrs</u> <u>20 yrs</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> to <u>10/21/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/21/59</u> , 19 <u>59</u> , and that death occurred at <u>6 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>203 W. Maple Rd.</u>		DATE SIGNED <u>Linthicum Md.</u>	
PHYSICIAN'S NAME (Type) <u>Chas. L. Ball Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 24, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping &amp; Kirkley, Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	







10987

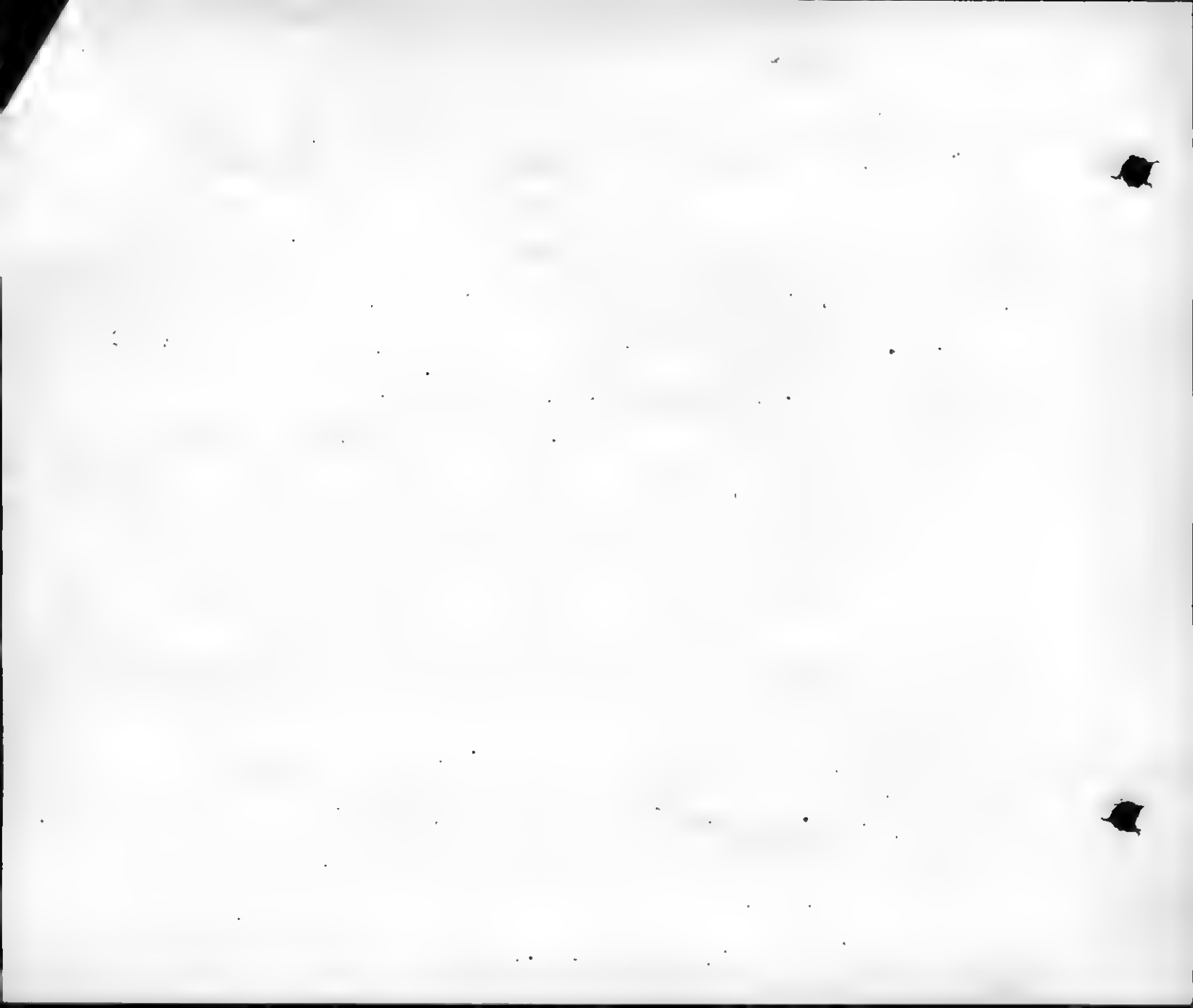
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sherwood Forest</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>aa</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sherwood Forest</u> d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPHINE</u> Middle <u>MACDONALD</u> Last <u>MACDONALD</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 24 1884</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>STANLEY PRZYBYLOWSKI</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT Address <u>William Macdonald #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PANCREAS</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 WKS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>					
21. I certify that I attended the deceased from <u>1 OCT</u> , 1959, to <u>23 OCT</u> , 1959, that I last saw the deceased alive on <u>23 OCT</u> , 1959, and that death occurred at <u>8:00 P.</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Edward J. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Southgate Ave</u>		DATE SIGNED <u>10/24/59</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>—</u>		22b. DATE THEREOF <u>OCT 27 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAKLAND CEM.</u>	
22d. LOCATION (City, town, or county) <u>PHILADELPHIA PA.</u>		(State) <u>—</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>Sons Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>OCT 27 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10939

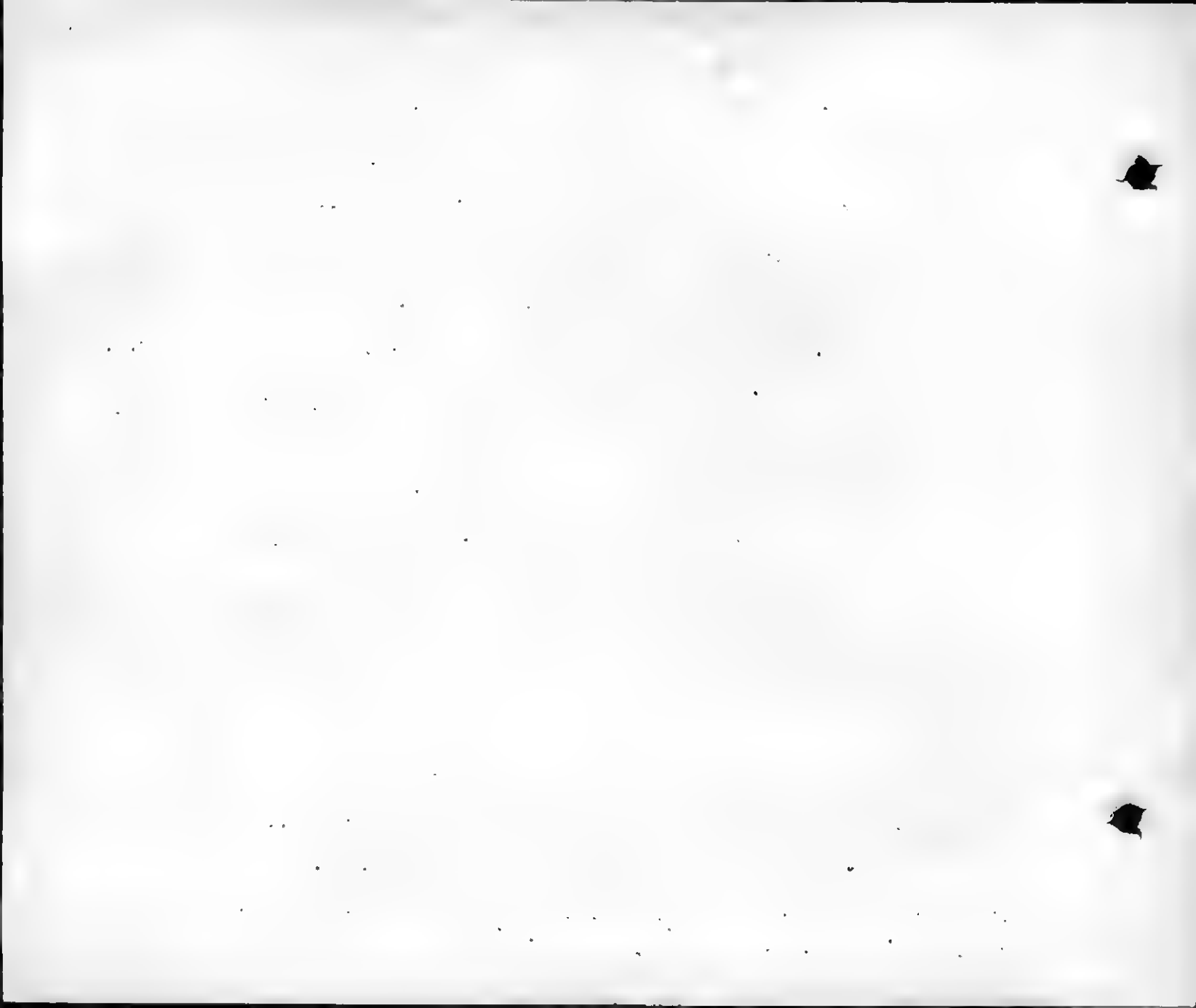
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Res dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				1 d. STREET ADDRESS <b>161 Green St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Ada</b> Middle <b>Lee</b> Last <b>MACE</b>		4. DATE OF DEATH		Month <b>October</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 13, 1884</b>		9. AGE (In years lost birthday) <b>74</b> yrs	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WASHINGTON A MARCHANT</b>				14. MOTHER'S MAIDEN NAME <b>ADA A LYON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>CHARLES B. MACE</b>		<b>(2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple emboli</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Endocardial thrombi + auricular fibrillation</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>5 yrs.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>55</b> , to <b>Oct</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct 26</b> , 19 <b>59</b> , and that death occurred at <b>5:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>121 Cathedral St.,</b> DATE SIGNED <b>10/27/59</b>							
ACTUAL SIGNATURE <b>John Hedeman</b>		M.D.		<b>121 Cathedral St.,</b>		<b>10/27/59</b>	
PHYSICIAN'S NAME (Type) <b>John Hedeman</b>		<b>Annapolis, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 29-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Annes Cent</b>		22d. LOCATION (City, town, or county) <b>Annapolis Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Doyle Sons</b>		ADDRESS <b>Annapolis Md</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Fennell</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10954

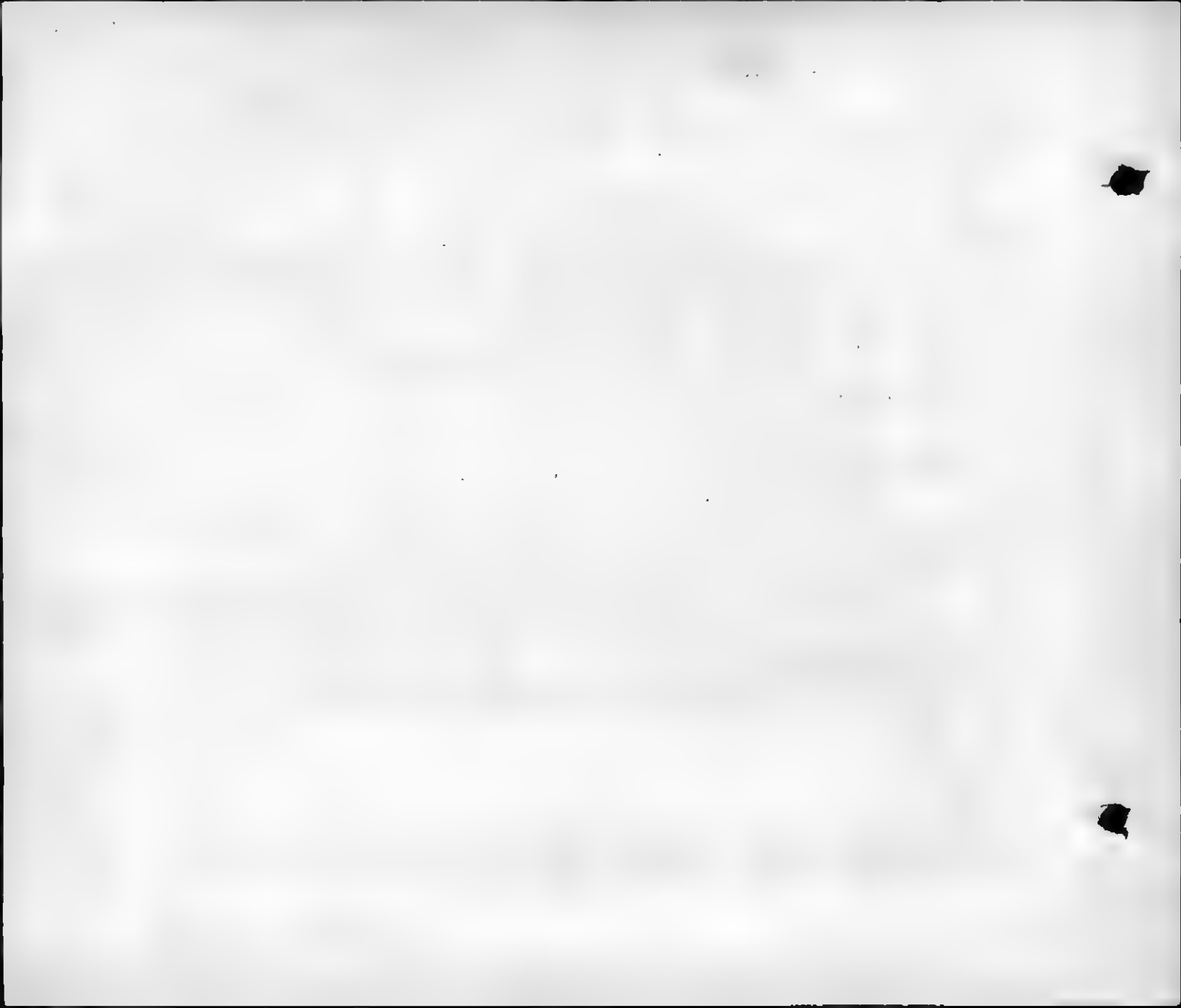
CERTIFICATE OF DEATH

Reg. Dist. No.

10940

1 PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Campbell</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>U. S. General</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lynchburg</i>	
3 NAME OF DECEASED (Type or print) First <i>Boyd</i> Middle <i>Lawrence</i> Last <i>Madeox</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>19</i> Year <i>1959</i>	
5 SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 2-1881</i>
9. AGE (In years last birthday) <i>78</i> yrs		IF UNDER 1 YEAR: Months <i>7</i> Days <i>8</i> Hours <i>15</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cabinet Maker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cabinet Maker</i>	
11 BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>James Madeox</i>		14. MOTHER'S MAIDEN NAME <i>Martha Clark</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> No <input type="checkbox"/> or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Arie C. Madeox</i>		Address <i>(2)</i>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Due to</i> (c) <i>Due to</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-18-59</i> to <i>10-19-59</i> , that I last saw the deceased alive on <i>10-19-59</i> , 19 <i>59</i> , and that death occurred at <i>4 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank M. Shipler</i> M.D.		ADDRESS (Street, city or town, state) <i>121 Cathedral St</i> DATE SIGNED <i>10-19-59</i>	
PHYSICIAN'S NAME (Type) <i>Frank M. Shipler</i>		<i>Annapolis, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>Oct 21-59</i>	<i>Springtree Remt</i>	<i>Lynchburg Va</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Sawyer Sons</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR DATE <i>OCT 26 '59</i>		24b. REGISTRAR'S SIGNATURE <i>William S. Hearn</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10988

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u>		b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Michael Joseph Manning 528 Manor Rd.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Michael Joseph Manning</u>		First		Middle		Last	
4. DATE OF DEATH <u>October 24th</u>		Month		Day		Year <u>19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/17/58</u>		9. AGE (in years last birthday) <u>1</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Manning</u>				14. MOTHER'S MAIDEN NAME <u>Patricia Cuddy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		INFORMANT <u>Mr. and Mrs. R. Manning (parents.)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary infection</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diarrhea</u> DUE TO (c) <u>Dehydration</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/21/59</u> , 19 <u>59</u> , to <u>10/24/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/24/59</u> , 19 <u>59</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Glen Burnie, Md.</u> <u>10/25/59</u>							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 27, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping &amp; Kirkley</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 28 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

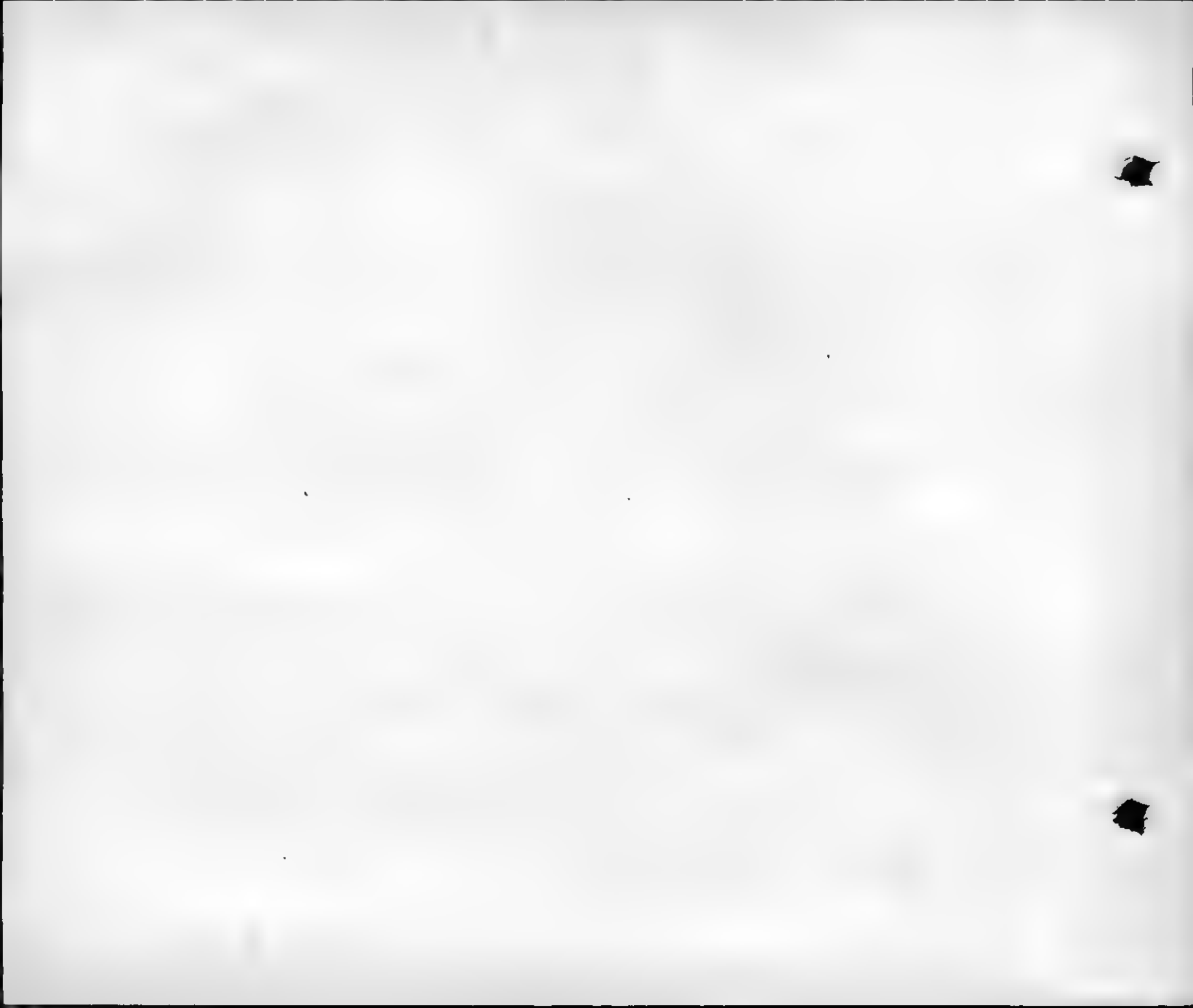
## 10989 Items 8 & 9 File 3-211 1-30/59.cac CERTIFICATE OF DEATH

10956

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>AA</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> <span style="float: right;">b. COUNTY <u>DD</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			c. LENGTH OF STAY IN 1b <u>720</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sunset Beach - Pasadena</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8418 RUGBY RD</u>				d. STREET ADDRESS <u>8418 RUGBY RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Enid</u> Middle <u>MASTERS</u> Last <u>MASTERS</u>				<b>4. DATE OF DEATH</b> Month <u>10</u> Day <u>- 18</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1915</u> <u>12-14-1915</u>	
9. AGE (In years last birthday) <u>43 1/4</u> yrs		IF UNDER 1 YEAR Months <u>4</u> Days <u>14</u> Hours <u>15</u> Min. <u>44</u>		IF UNDER 24 HRS Months <u>0</u> Days <u>14</u> Hours <u>15</u> Min. <u>44</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>OWEN Williams</u>				14. MOTHER'S MAIDEN NAME <u>Mary -</u>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>Family</u>		Address <u>Same</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>174X</u> <u>Brain (Metastatic)</u> DUE TO <u>carcinoma of the breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/17</u> , 19 <u>59</u> , to <u>5/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/17</u> , 19 <u>59</u> , and that death occurred at <u>12:15</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3471 FT. SMALLWOOD ROAD</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.				PHYSICIAN'S NAME (Type) <u>BRADY SMITH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home 130 E. Fort Ave</u>				ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>				24c. REGISTRAR'S SIGNATURE <u>—</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10990

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P.H.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. LENGTH OF STAY IN 1b <u>5 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>311 GLENWOOD AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Mary Miksanas</u>		4. DATE OF DEATH <u>10 22 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 26 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILORS.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LITHUANIA</u>	
11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>LITHUANIA</u>	
13. FATHER'S NAME <u>VINCAS MIKSAVNAS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>—</u>	
17. INFORMANT <u>MARIE HOFFMANN</u>		Address <u>311 GLENWOOD AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAY 1959</u> to <u>October 1959</u> , that I last saw the deceased alive on <u>10-21-59</u> , 19 <u>59</u> , and that death occurred at <u>5:34 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C.R. MacDonald M.D.</u>		ADDRESS (Street, city or town, state) <u>204 Cedar Hill</u> DATE SIGNED <u>10-22-59</u>	
PHYSICIAN'S NAME (Type) <u>C.R. MacDonald</u>		<u>Glen Burnie, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT. 26, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MOST HOLY REDEEMER</u>	22d. LOCATION (City, town, or county) (State) <u>BELAIR RD MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Jacobson</u>		24a. REC'D BY REGISTRAR <u>OCT 26 59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles W. Jacobson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10941

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>1 day</b>		2. USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lothian</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		/d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>UNNAMED</b> Middle Last <b>Moreland</b>		4. DATE OF DEATH Month <b>October</b> Day <b>10</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 9, 1959</b>	9. AGE (In years lost birthday) yrs <b>1</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>3</b> Hours <b>15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>John Clifton MORELAND</b>		14. MOTHER'S MAIDEN NAME <b>Esther Doreather MORELAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Hospital records</b>		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 9, 1959</b> to <b>Nov. 10, 1959</b> , that I last saw the deceased alive on <b>Nov. 10, 1959</b> , and that death occurred at <b>8:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>62 Cathedral St.,</b> DATE SIGNED <b>11/11/59</b> ACTUAL SIGNATURE <b>G T Allen</b> M.D. PHYSICIAN'S NAME (Type) <b>A. T. Allen</b> <b>Annapolis, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-11-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>	
22d. LOCATION (City, town, or county) (State) <b>Lothian, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Friend</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr. - Annapolis, Md.</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10991

## CERTIFICATE OF DEATH

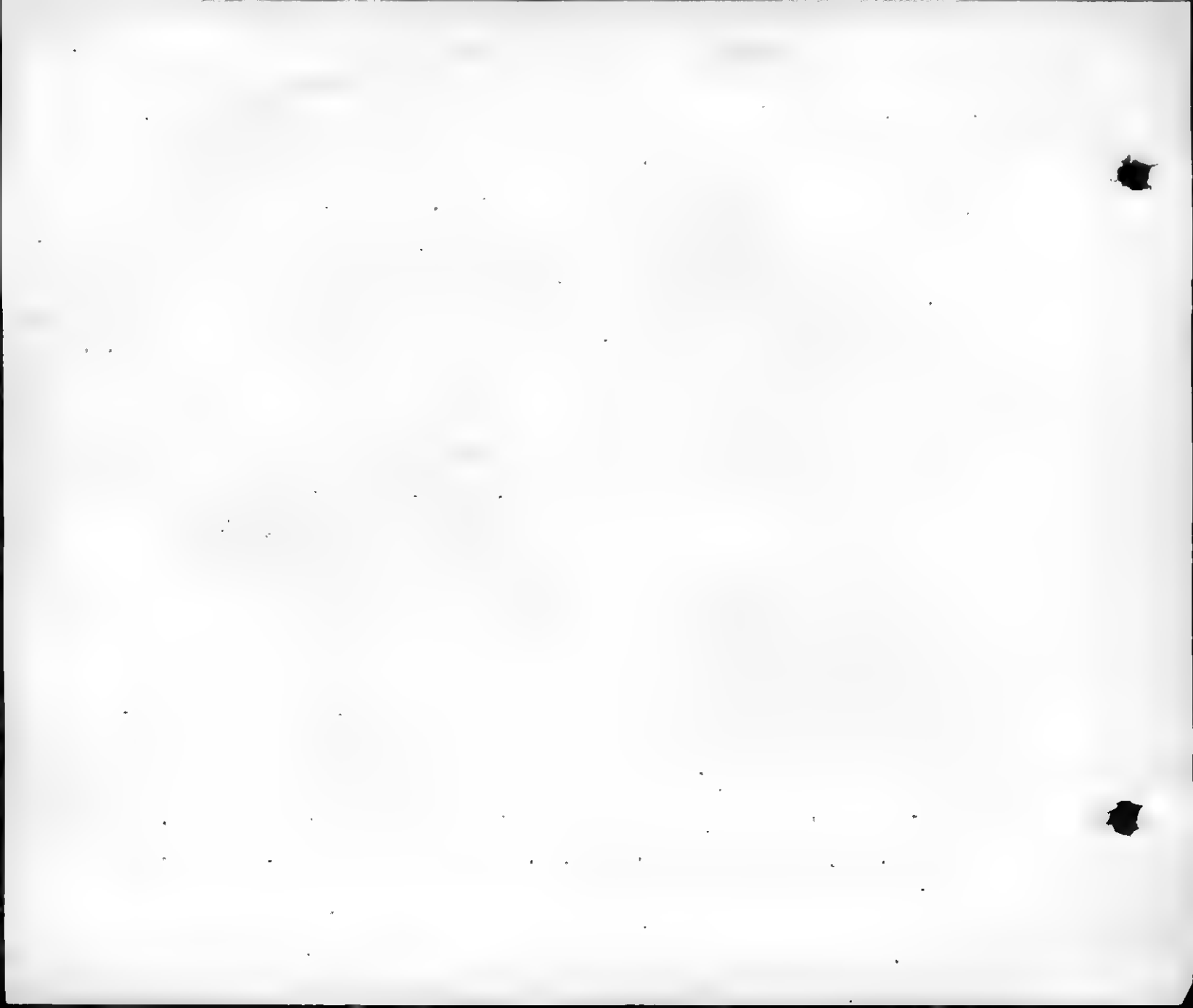
## 10958

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>9yr. 13 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>804 W. Saratoga Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Arthur Morrow</b>				4. DATE OF DEATH Month Day Year <b>10 10 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1898?</b>	
9. AGE (In years last birthday) <b>61?</b> yrs.		10. AGE UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Hospital Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremia, secondary to aortic insufficiency</b> <b>023X</b> DUE TO <b>Syphilis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dementia</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----			
20c. TIME OF INJURY Month. Day. Year Hour <u>  </u> <u>  </u> <u>  </u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/27</u> 19 <u>50</u> , to <u>10/10</u> 19 <u>59</u> , that I last saw the deceased alive on <u>10/10</u> 19 <u>59</u> , and that death occurred at <u>10:35</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>10/13/59</b> ACTUAL SIGNATURE <b>Hildegard Heard Reissman</b> PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md.</b> <b>10/13/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Vernon</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Op'm Reese</b>				24a. REC'D BY REGISTRAR <b>10-14-59</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. E. Kline</b>	

OCT 21 '59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

10959

10992

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY OR TOWN <u>Shady Side, Md.</u>		CITY OR TOWN <u>Shady Side, Md.</u>	
CITY OR TOWN <u>Shady Side</u>		LENGTH OF STAY (in this place) <u>Life</u>		STREET ADDRESS <u>1</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print!) <u>Rosie</u> (First) <u>Moulden</u> (Middle) <u></u> (Last)				4. DATE OF DEATH <u>Oct-26-1959</u> (Month) (Day) (Year)			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 17 1880</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Churchton Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Jacob Gross</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Blount</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Robert Moulden Shady Side</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Anterior Septal My infarction</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiovascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Grade IV</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> el work <input type="checkbox"/> Not while el work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 13, 1958</u> to <u>Oct 26, 1959</u> , that I last saw the deceased alive on <u>Oct 26, 1959</u> , and that death occurred at <u>11:55 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>R. K. Dickerson</u>		DATE SIGNED <u>Oct 26, 1959</u>		ADDRESS <u>110 CHERRY ST ANNAPOLIS MD.</u>		DATE SIGNED <u>10/28/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 28, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Franklin</u>		LOCATION (City, town, or county) (State) <u>Churchton Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u></u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Benedict Harsanyi</u>		ADDRESS <u>Salisbury Md.</u>	
DATE <u>NOV 4 '59</u>							



## CERTIFICATE OF DEATH

Reg. Dist. No.

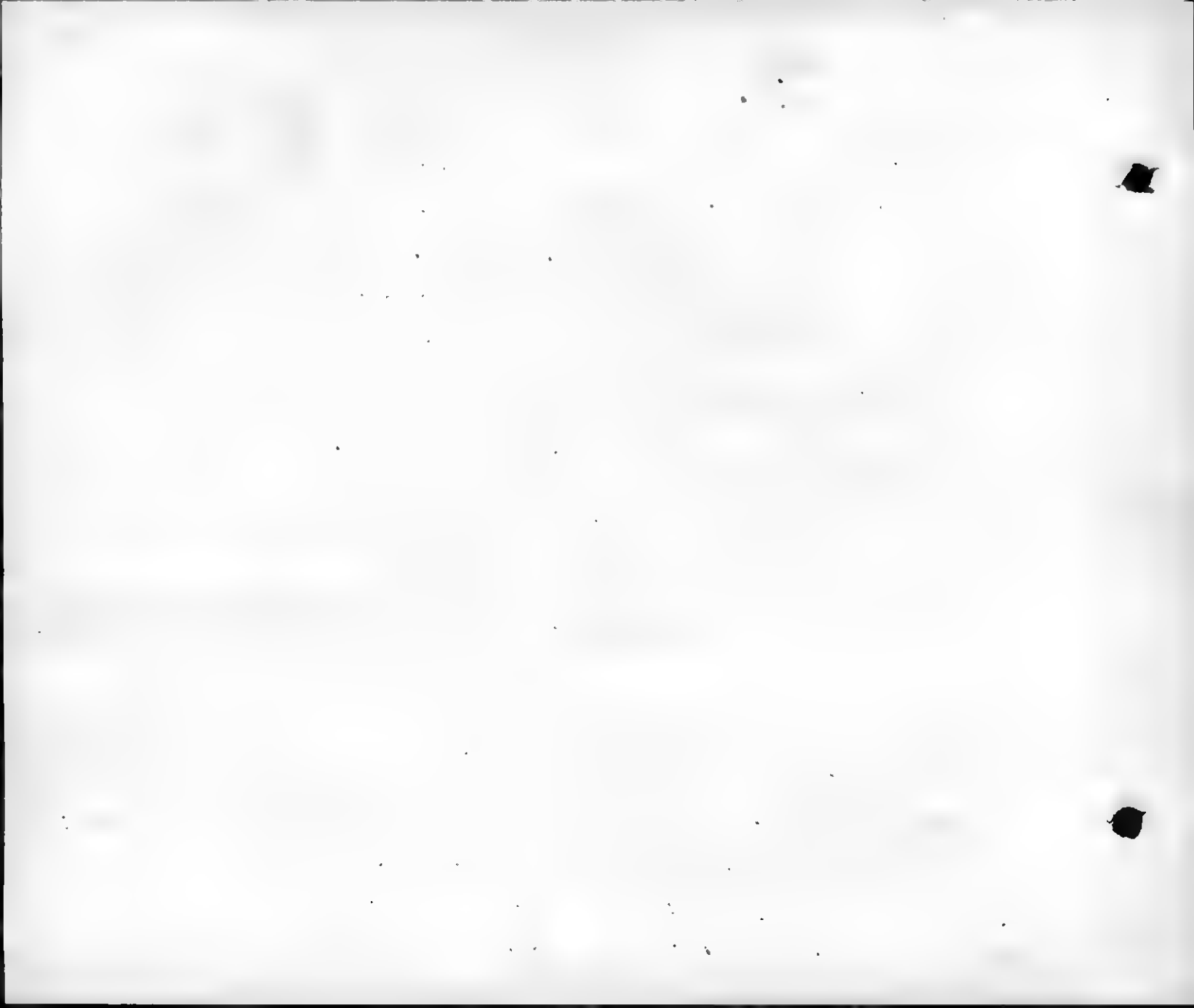
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1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>A.A. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ARNOLO</b> Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ARNOLO</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>A.A. GENERAL Hospital</b>		d. STREET ADDRESS <b>Box 550 Rt. #2 ARNOLO</b>	
3. NAME OF DECEASED (Type or print) <b>ETHEL</b> First <b>A.</b> Middle <b>MURPHY</b> Last		4. DATE OF DEATH <b>10</b> Month <b>8</b> Day <b>1959</b> Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-17-1899</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR <b>60</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ADAM HORNER</b>		14. MOTHER'S MAIDEN NAME <b>MATILDA PERT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>MRS. GEORGE WEHR #2</b>		Address <b>#2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> <b>422.1</b> DUE TO <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (b) <b>—</b> DUE TO (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10/8</b> , 19 <b>59</b> , to <b>10/8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/8</b> , 19 <b>59</b> , and that death occurred at <b>2:05 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard W. Peeler</b> M.D.		ADDRESS (Street, city or town, state) <b>121 CATHERAL ST BALTIMORE MD.</b> DATE SIGNED <b>10/8/59</b>	
PHYSICIAN'S NAME (Type) <b>RICHARD W. PEELER</b>		<b>ANNAPOLIS, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>BURIAL</b>	<b>10-10-59</b>	<b>LOXODON PARK</b>	<b>BALTIMORE MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor &amp; Sons Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 13 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10943

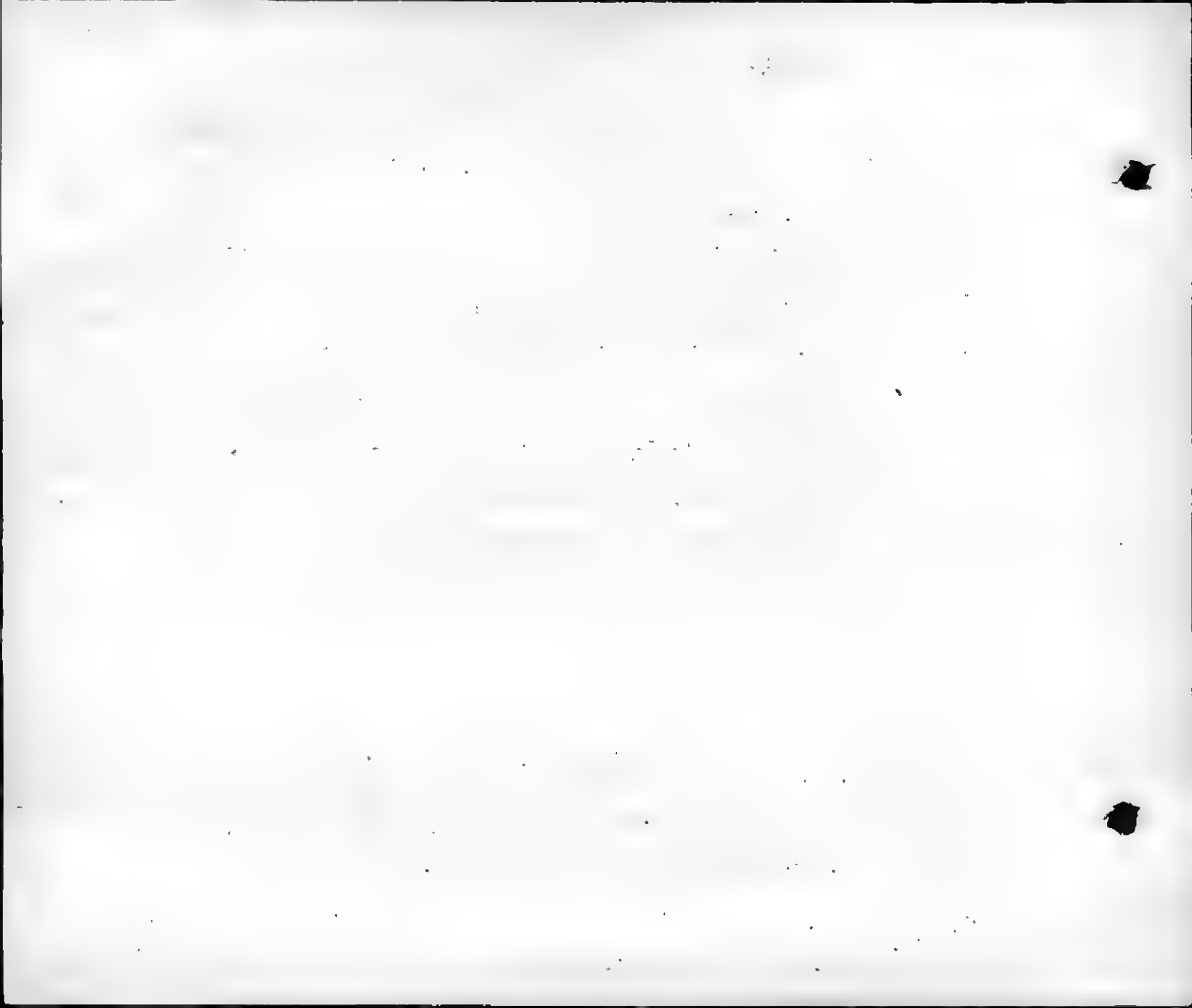
## CERTIFICATE OF DEATH

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>10</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LOUIS S MYERS</b>		First		Middle		Last		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>23</b> Year <b>19 59</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 7, 1889</b>		9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>70</b>		11. IF UNDER 24 HRS Days <b>70</b>		12. IF UNDER 24 HRS Hours <b>70</b>		13. IF UNDER 24 HRS Min. <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter, Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Severn, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>214-05-0721</b>		INFORMANT <b>Mr John R. Myers-</b>		1705 Virginia Street <b>Annapolis, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>gen. carcinomatosis</b> <b>150X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>carcinoma of esophagus</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>June 10, 19 59</b> , to <b>Oct 23, 19 59</b> that I last saw the deceased alive on <b>Oct. 22, 19 59</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.	
21. I certify that I attended the deceased from <b>June 10, 19 59</b> , to <b>Oct 23, 19 59</b> that I last saw the deceased alive on <b>Oct. 22, 19 59</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Amos Garrett Blvd., Annapolis</b>		DATE SIGNED <b>10/26/59</b>		ACTUAL SIGNATURE <b>S. Borssuck</b> M.D.		PHYSICIAN'S NAME (Type) <b>S. Borssuck MD</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 26 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Frank</b>		25. I certify that I attended the deceased from <b>June 10, 19 59</b> , to <b>Oct 23, 19 59</b> that I last saw the deceased alive on <b>Oct. 22, 19 59</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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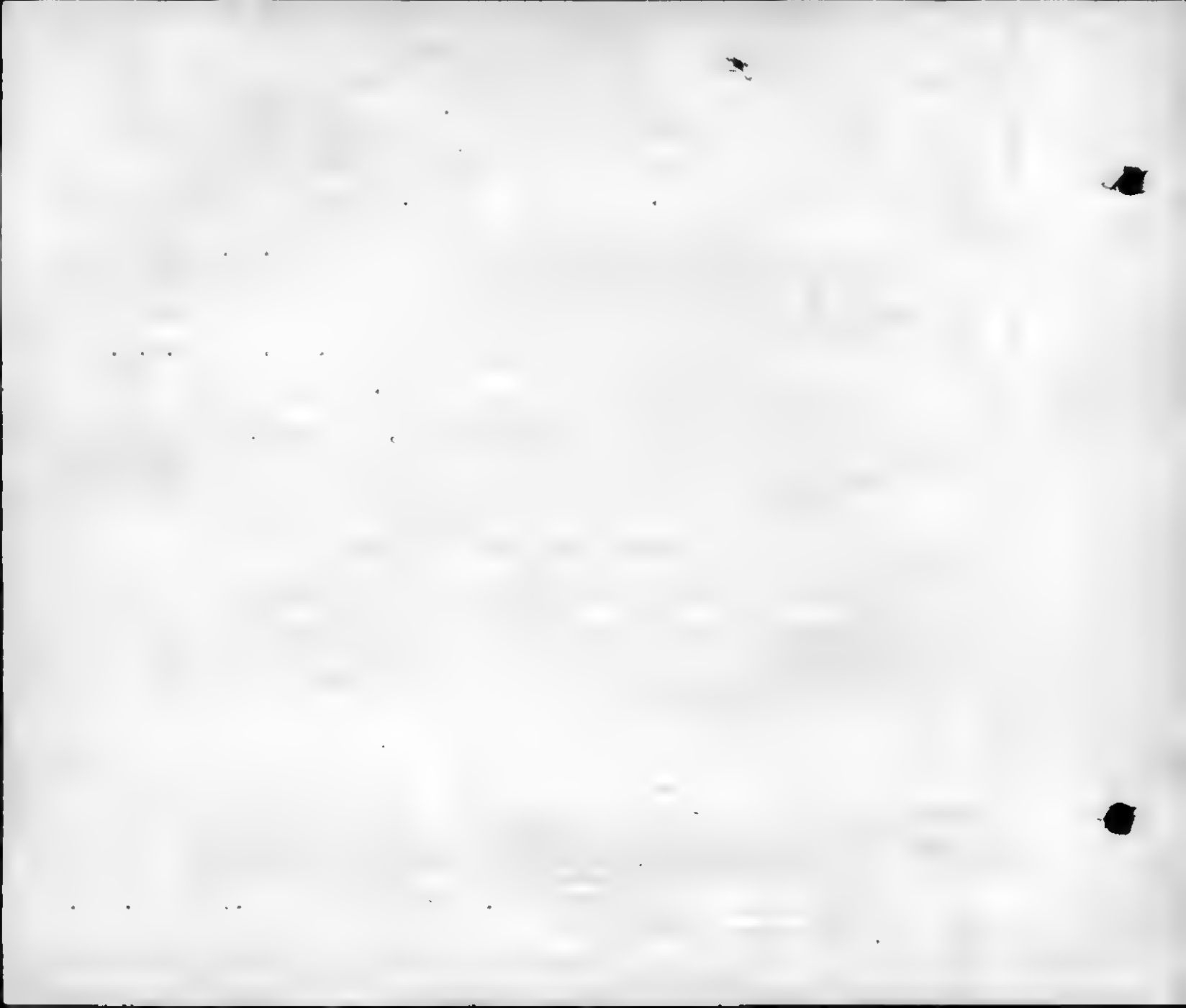
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum Heights</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum Heights</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>629 Hammonds Ferry Rd.</b>		d. STREET ADDRESS <b>629 N. Hammonds Ferry Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>ESTELLA</b> Last <b>NORTON</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/18/1900</b>
9. AGE (In years last birthday) <b>59</b>		IF UNDER 1 YEAR: Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Martinsburg, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rubin F. DeLancey</b>		14. MOTHER'S MAIDEN NAME <b>Laura M. Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Carolyn Hill, daughter, above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC INSUFFICIENCY</b> DUE TO <b>CARCINOMATOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma uterine</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>1 year</b> <b>NOV. 1954</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia, Secondary to Carcinomatosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>DEC. 1953</b> to <b>OCT 4, 1959</b> , that I last saw the deceased alive on <b>OCT 4, 1959</b> , and that death occurred at <b>6:20 P.M.</b> from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED <b>OCT. 5, 1959.</b>	
ACTUAL SIGNATURE <b>K. Krulovitz</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Kenneth Krulovitz M.D.</b>		<b>400 N HILTON ST. BALTO, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/7/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>	22d. LOCATION (City, town, or county) (State) <b>Richie Hwy., Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 7 '59</b>	
ADDRESS <b>3331 Bréhms Lane</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (if not in hospital, give street address) OF INSTITUTION <u>Anne Arundel General</u>		2 USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mt. Victoria</u> d. STREET ADDRESS <u>Yatten Farm</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Jewett</u> Last <u>Orth</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>24</u> Year <u>1959</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13, 1891</u>
9 AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>	IF UNDER 24 HRS. Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Henry J. Orth, Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Ann Blackston</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war or date of service) <u>WW II</u>	
16. SOCIAL SECURITY NO. <u>Harriet C. Orth</u>		17. ADDRESS <u>#2.</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Posterior Myocardial Infarction</u> DUE TO <u>Coronary artery Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>8-10 yrs.</u> (b) <u>8-10 yrs.</u> (c) <u>8-10 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chn. Bronchitis</u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , to <u>10-24-1959</u> , that I last saw the deceased alive on <u>10-24-59</u> , and that death occurred <u>USA</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>121 Cathedral St</u> DATE SIGNED <u>10-24-59</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		<u>Annapolis, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-27-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Shipley Sons Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 29 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician's office. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

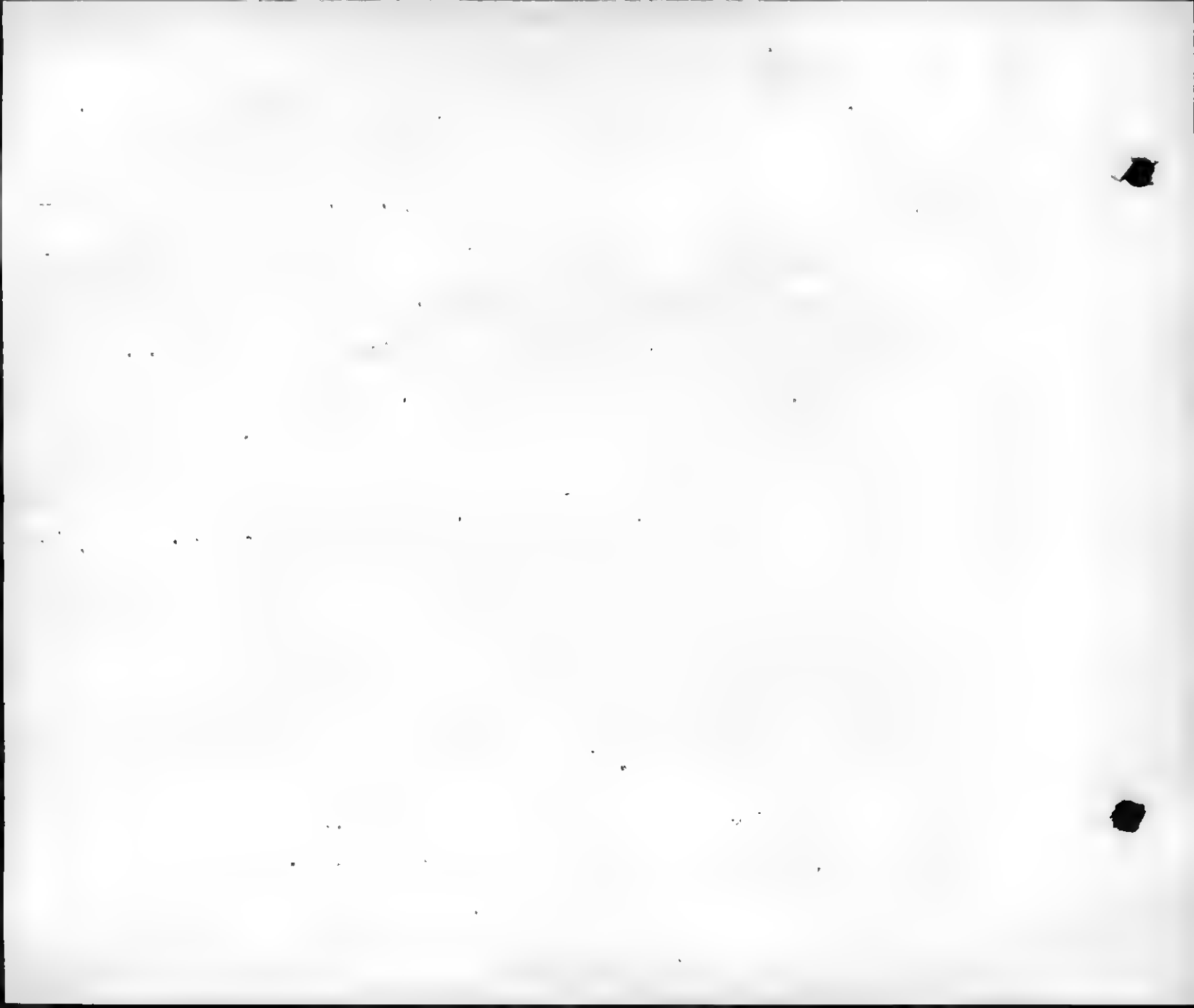
Reg. Dist. No.

10945

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>102 Roosevelt Court</b>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>S.</b> Last <b>OWEN</b>		4. DATE OF DEATH Month <b>October</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1884</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>17</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS Months <b>7</b> Days <b>17</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>James D. Owen</b>	
14. MOTHER'S MAIDEN NAME <b>Ellen Worden</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>David H. Owen</b>		INFORMANT Address <b>#2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b> 44 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July</b> , 19 <b>58</b> , to <b>10-17-1959</b> , that I last saw the deceased alive on <b>10-17-1959</b> , and that death occurred at <b>10:00PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James R. Martin</b>		ADDRESS (Street, city or town, state) <b>6 Shaw St., Annapolis, Md.</b>	
PHYSICIAN'S NAME (Type) <b>James R. Martin</b>		DATE <b>10/19/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-20-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Edwards Chapel</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor &amp; Sons</b>		24a. REC'D BY REGISTRAR <b>Oct 21 59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

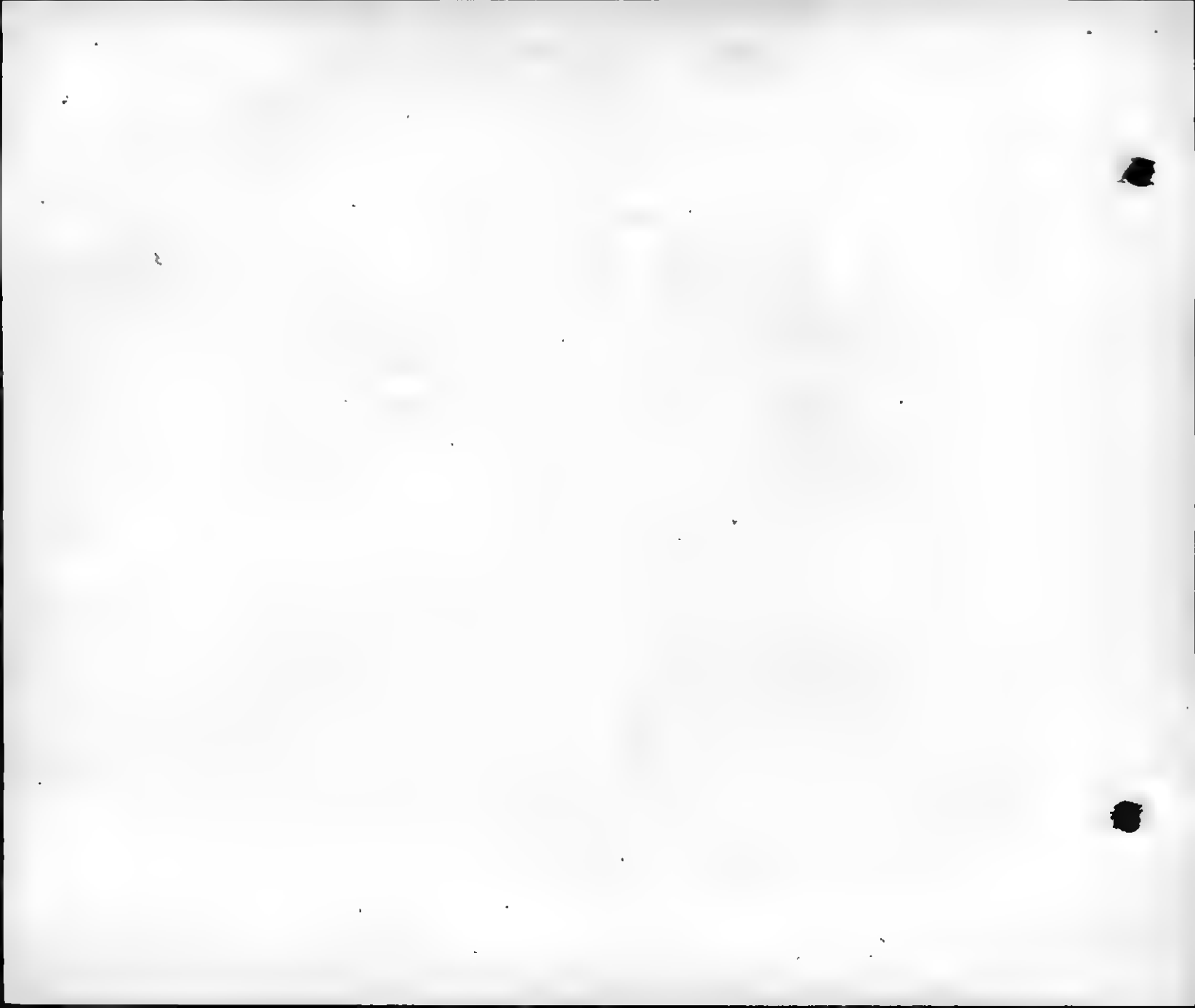


10946

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen'l. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>322 Roosevelt Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clyde W. Owens</u>				4. DATE OF DEATH Month Day Year <u>Oct. 13 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 April 1895</u>	9. AGE (In years last birthday) <u>64 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Linemanager (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Belts. Trans. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(Unknown) Owens</u>				14. MOTHER'S MAIDEN NAME <u>(Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 2 213-05-9076</u>		INFORMANT <u>Mrs. Elita M. Owens</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism?</u> <u>420.1</u> DUE TO <u>Anterior Myocardial Infarction 11 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hyper Zoster</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19__		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>10-2-59</u> , 19 <u>59</u> , to <u>10-13-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-13-59</u> , 19 <u>59</u> , and that death occurred at <u>3:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>121 Cathedral St 10x309 Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>17 Oct. 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 19 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			



1  
FOR STATE  
HEALTH DEPT.  
17

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

10966

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>10947</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN <b>MD</b> <b>10</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>In front of 1193 Tyler Avenue</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>1200 Brashears Street</b>			
3. NAME OF DECEASED (Type or print) <b>FRANCIS GRIFFITH OWENS</b>		4. DATE OF DEATH Month <b>October</b> Day <b>14</b> Year <b>1959</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 4, 1903</b>		9. AGE (in years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR: Months <b>11</b> Days <b>14</b> Hours <b>19</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Greyhound Bus Lines</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Bus Driver</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles G. Owens</b>				14. MOTHER'S MAIDEN NAME <b>Mary L. Owens</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Betty L. Owens # 2</b>		Address <b>-</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>-</b>						INTERVAL BETWEEN ONSET AND DEATH <b>-</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>					
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>1959</b> Hour <b>a.m.</b> <b>p.m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) <b>-</b> (County) <b>-</b> (State) <b>-</b>	
21. I certify that I took charge of the remains described above, held an <b>Autopsy</b> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>		M.D. <b>W. Bradley King, Jr., M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>10/14/59</b>		Address (Street, city, town, or county) <b>-</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		22d. LOCATION (City, town, or country) <b>Annapolis, Md.</b>	
23. FUNERAL DIRECTOR <b>John M. Taylor and Sons</b>				ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 19 1959</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10967

Reg. Dist. No.

10948

FOR STATE  
HEALTH DEPT.

<b>1 PLACE OF DEATH</b> a. COUNTY <u>ANNE ARUNDEL</u> <u>MARYLAND</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admision) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>129 Severn Ave.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>129 Severn Ave.</u>				e. STREET ADDRESS <u>129 Severn Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>THOMAS F PATTERSON</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>OCTOBER 1, 19 59</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1897</u>			
<b>9. AGE</b> (in years last birthday) <u>62 yrs</u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Male practical nurse, Ret. General Hospital</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Lima, Ohio</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>USA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Unknown</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes WW I</u>		<b>16. SOCIAL SECURITY NO.</b> <u>287 05 2110</u>			
<b>17. INFORMANT</b> <u>Personal papers of Deceased</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <u>434.4</u> <b>IMMEDIATE CAUSE (a)</b> <u>CARDIAC DISEASE</u> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <u>434.4</u> <b>DUE TO</b> <b>(b)</b> <u>434.4</u> <b>DUE TO</b> <b>(c)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Natural causes</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>XX</u> p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Annopolis, Maryland</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from.</b> <u>Natural causes</u> <input checked="" type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined monner</u> <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Elmer G. Linhardt</u>		<b>EXAMINER'S NAME (Type)</b> <u>Elmer G. Linhardt</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Oct. 3, 1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Hillcrest Memorial Cem.</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Annopolis, Maryland</u>		<b>24b. REC'D BY REGISTRAR</b> <u>DATE OCT 6 '59</u>		<b>24c. REGISTRAR'S SIGNATURE</b> <u>Arthur J. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



10949

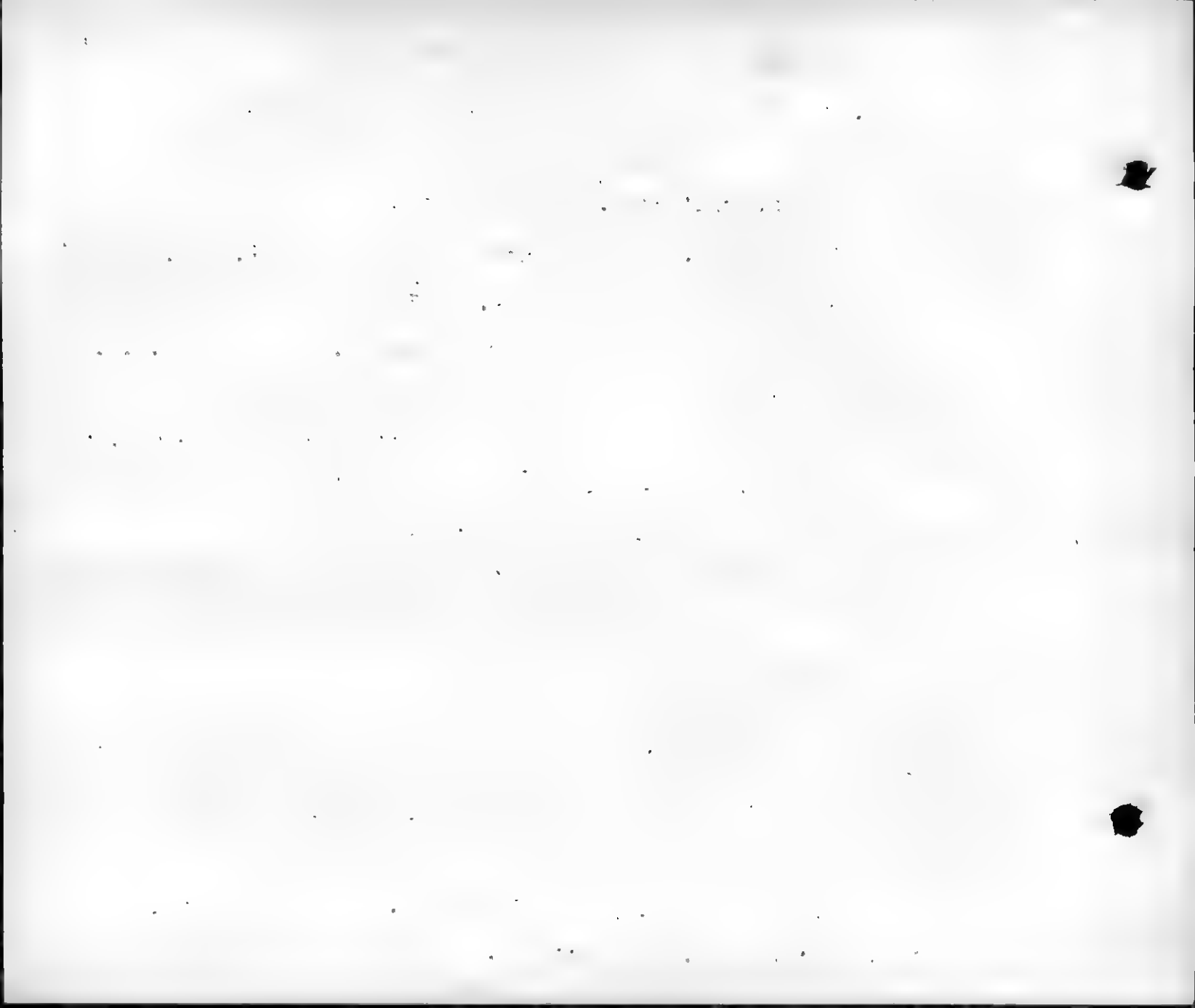
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>Annapolis</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>Annapolis</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Annapolis General Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Glenburnie</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Freetown</b> d. STREET ADDRESS <b>Box 318</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>E.</b> Last <b>Pearman</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1917</b> <b>Oct. 3, 1917</b>
9. AGE (In years last birthday) <b>42</b> yrs		10. IF UNDER 1 YEAR Months <b>42</b> Days <b>42</b> Hours <b>42</b> Min <b>42</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Freetowne Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Brown</b>		14. MOTHER'S MAIDEN NAME <b>Luvenia Brady</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Thomas Pearman</b>		Address <b>Box 318 Freetown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastases to vital organs</b> DUE TO <b>Carcinoma of cervix</b> Conditions if any which gave rise to immediate cause (b), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-26-59</b> , 19, to <b>10-25-59</b> , 19, that I last saw the deceased alive on <b>10-25-59</b> , 19, and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above. DATE SIGNED <b>6-6-60</b>			
ACTUAL SIGNATURE <b>A. T. Allen</b>		M.D. <b>6-6-60</b>	
PHYSICIAN'S NAME (Type) <b>A T ALLEN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10/28/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Marley Neck Church Yd.</b>	
22d. LOCATION (City, town, or county) (State) <b>Marley Neck Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Isaiah L. Brown &amp; Son</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 28 '59</b>	
ADDRESS <b>108 W. Montgomery St.</b>		24b. REGISTRAR'S SIGNATURE <b>Isaiah L. Brown</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

10969

Reg. Dist. No.

10950

1. PLACE OF DEATH a. COUNTY <u>A.A.Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>309 ADAMS St.</u>		d. STREET ADDRESS <u>309 ADAMS St.</u>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>H.</u> Last <u>PHILLIPS</u>		4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. N.E.E.S.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAVY SERVICE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES H. PHILLIPS</u>		14. MOTHER'S MAIDEN NAME <u>EMMA ANN DALE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>WILBUR R. PHILLIPS #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CORONARY ARTERY DIS.</u> DUE TO (c) <u>HYPERTENSION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 MINUTES</u> <u>5 YEARS</u> <u>5 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 MAY, 1957</u> , to <u>10-31, 1959</u> , that I last saw the deceased alive on <u>10-27, 1959</u> , and that death occurred at <u>11P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Southgate AVE</u> DATE SIGNED <u>11/3/59</u>	
PHYSICIAN'S NAME (Type) <u>ANNAPOLIS MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-3-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 4 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Edward S. Beck</u>	



10951

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>D.</u> Last <u>Reed</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 15-1909</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mgr. J.C. Murphy Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mgr. J.C. Murphy Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Reesport Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Harry L. Reed</u>		14. MOTHER'S MAIDEN NAME <u>Elinabeth Beckers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Margaret L Reed</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC CORONARY/ARTERY DISEASE</u> DUE TO (c) <u>1 YEAR</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 MINUTES</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PREVIOUS CORONARY OCCLUSION JUNE 1957</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE</u> , 1958, to <u>4 OCT</u> , 1959, that I last saw the deceased alive on <u>1 OCT</u> , 1959, and that death occurred at <u>1205A</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u> <u>Annapolis Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct 6-59</u>	<u>Glen Haven Cont</u>	<u>Glen Burnie Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sins</u> ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		<u>DATE 7 '59</u>	<u>Chas. &amp; H. ...</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

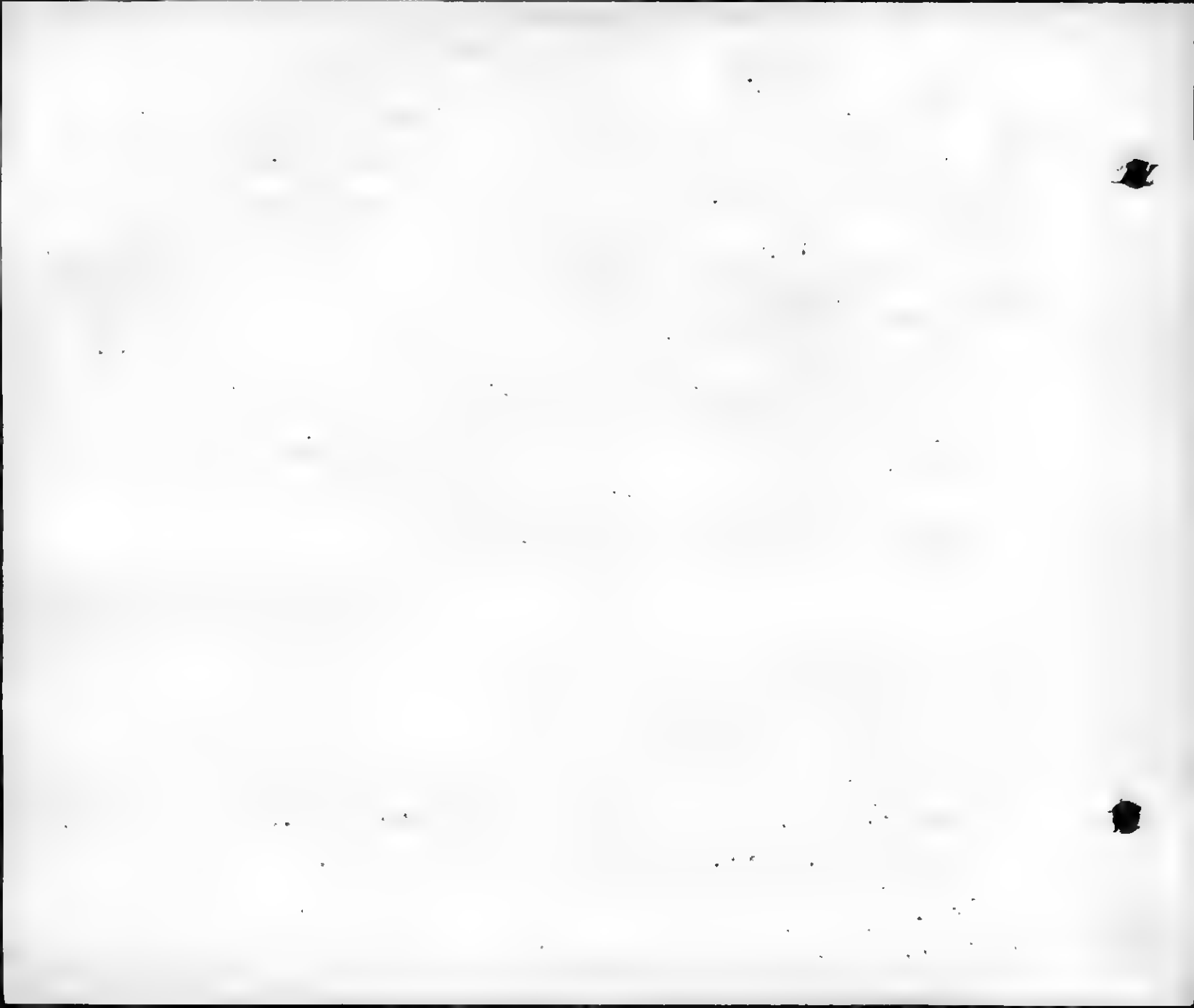
10972

10952

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Annapolis - Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. d. STREET ADDRESS <b>Shady Oaks Trailer Camp</b>	
3. NAME OF DECEASED (Type or print) First <b>Rhoda</b> Middle <b>P.</b> Last <b>ROHAN</b>		4. DATE OF DEATH Month <b>October</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1899</b>
9. AGE (In years last birthday) <b>60 yrs</b>		10. IF UNDER 1 YEAR Months <b>60</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CHARLES SNYDER</b>		14. MOTHER'S MAIDEN NAME <b>KATIE WILLIAMS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mrs. Louis FUELNER</b>		Address <b># 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>120.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery sclerosis</b> DUE TO (c) <b>-</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 1955, to <b>October</b> , 1959, that I last saw the deceased alive on <b>Oct 22</b> , 1959, and that death occurred at <b>1:10</b> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>121 Cathedral St., Annapolis, Md.</b> DATE SIGNED <b>10/23/59</b>			
ACTUAL SIGNATURE <b>John C. Hedeman</b>		M.D. <b>121 Cathedral St., Annapolis, Md.</b>	
PHYSICIAN'S NAME (Type) <b>John C. Hedeman</b>		ADDRESS <b>Annapolis, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-26-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor</b>		ADDRESS <b>Annapolis, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Frank</b>	



Rev. William Schmeiser

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>A. A.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> <b>0355</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>A. A. County Hosp.</b>		d. STREET ADDRESS <b>227 Linden Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Rev. William</b> Middle <b>Schmeiser</b> Last <b>Schmeiser</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1889</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min. <b>70</b>	11. IF UNDER 24 HRS. Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min. <b>70</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clergyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Methodist Church</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Md.</b>	
13. FATHER'S NAME <b>Henry Schmeiser</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Brendel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO <b>219-01-8932</b>	
17. INFORMANT <b>Mr. Leroy Schmeiser - Route 2, Box 57</b>		Address <b>Annapolis, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442X</b> DUE TO <b>Nephrosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost (b) <b>57 years</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ca of prostate, Diarrhea, cfr - A.C.V.D. Sub</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>9-10-59</b> to <b>10-17-59</b> , that I last saw the deceased alive on <b>10-17-59</b> , and that death occurred at <b>3 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank M. Shipley</b> M.D.		ADDRESS (Street, city or town, state) <b>171 Cathedral St</b>	
DATE SIGNED <b>10-17-59</b>		PHYSICIAN'S NAME (Type) <b>Frank M. Shipley</b> <b>Annapolis, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/20/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William J. Lickner &amp; Sons - Balt 17</b>		24a. REC'D BY REGISTRAR <b>Oct 19 59</b>	
ADDRESS <b>med</b>		24b. REGISTRAR'S SIGNATURE <b>William J. Lickner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10994

## CERTIFICATE OF DEATH

10974

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Orange</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>				e. STREET ADDRESS <b>539 Kittridge Drive</b>			
				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BERT</b> Middle <b>-</b> Last <b>SHANNON SR</b>				4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>19 59</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4 March 1879</b>		9. AGE (In years last birthday) <b>80 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocer</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew Shannon</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>234-2-1542</b>		17. INFORMANT <b>Son, Bert Shannon Jr</b> Address <b>3957 Brooklyn Ave Balto, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>11/14/59</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Nephrosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>one month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3 Oct</b> , 19 <b>59</b> , to <b>3 Oct</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3 Oct</b> , 19 <b>59</b> , and that death occurred at <b>0045 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>J. B. Zachary</b> M.D.				US Army Hospital <b>3 Oct 59</b>			
PHYSICIAN'S NAME (Type) <b>J. B. ZACHARY, Capt., M.C.</b>				Ft Geo G. Meade, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/7/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Orlando, Florida</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b> ADDRESS <b>4107 Wilkens Avenue</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 7 '59</b>		24b. REGISTRAR'S SIGNATURE	



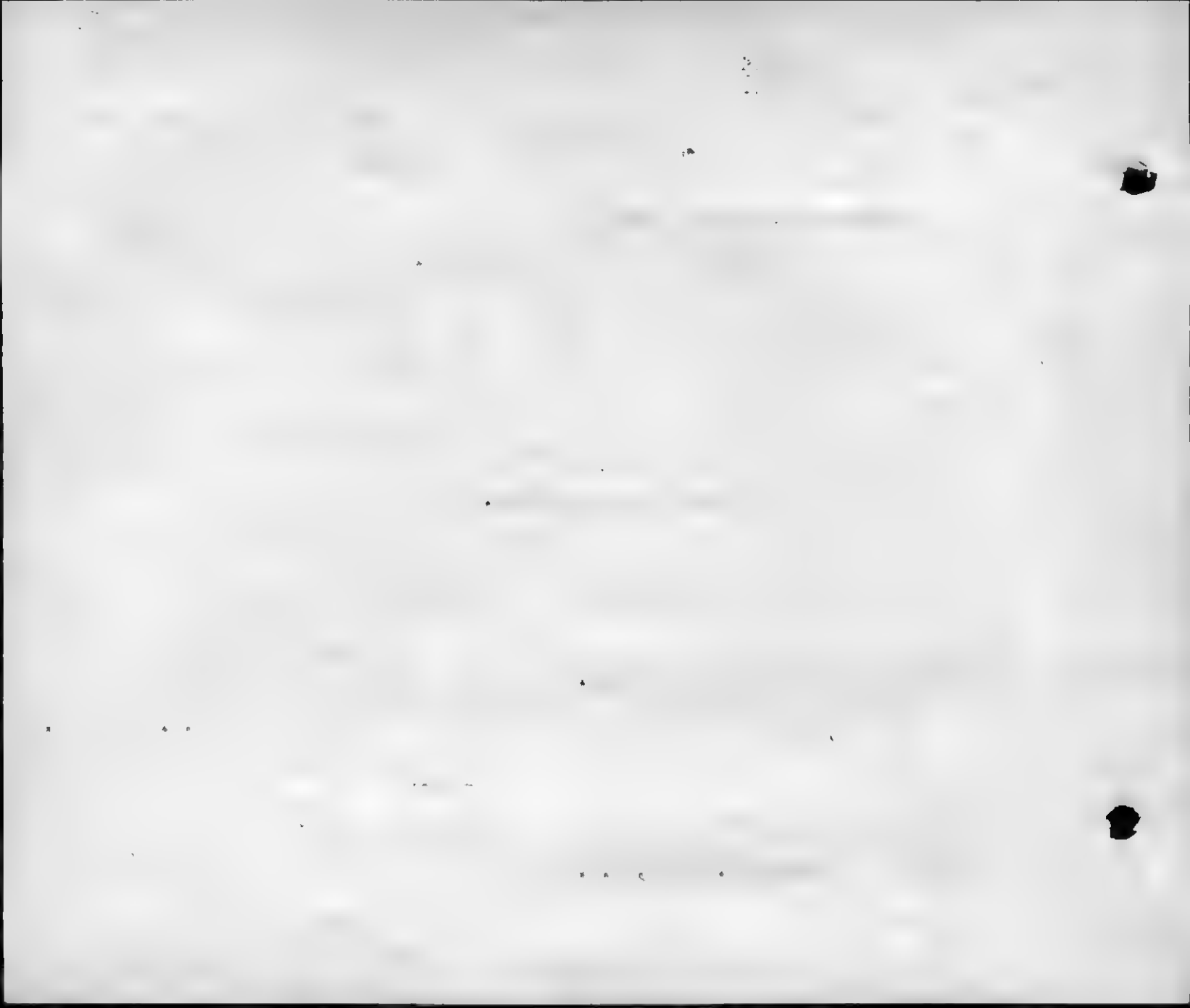
1.  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
10975											
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>						c. LENGTH OF STAY IN IL <b>Greenock</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>BERNARD SMITH, Sr.</b>						4. DATE OF DEATH Month <b>October</b> Day <b>25</b> Year <b>1959</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-7-22</b>		9. AGE (In years last birthday) <b>37</b> yrs.		IF UNDER 1 YEAR   IF UNDER 24 HRS. Months   Days   Hours   Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>						11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>					
13. FATHER'S NAME <b>Oliver Smith</b>						14. MOTHER'S MAIDEN NAME <b>Florence Jones</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>14-26-15</b>						16. SOCIAL SECURITY NO. <b>Hagner Booth</b>					
17. INFORMANT <b>Wings mel</b>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun Wound of Head.</b>											
DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO											
DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot in head.</b>											
20c. TIME OF INJURY Month, Day, Year Hour <b>10/25</b> 19 <b>59</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Greenock</b>		(County) <b>A.A.</b>		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Charles S. Petty</b>						DATE SIGNED <b>10/27/59</b>					
NAME (Type) <b>Charles S. Petty, M.D.</b>						Address (Street, c'ty, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-29-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>mt hope am</b>		22d. LOCATION (City, town, or country) <b>Sunderland Robert Co md</b>					
23. FUNERAL DIRECTOR <b>Wm G. Nelson</b>						24a. REC'D BY REGISTRAR <b>NOV 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Petty</b>			



10995

## CERTIFICATE OF DEATH

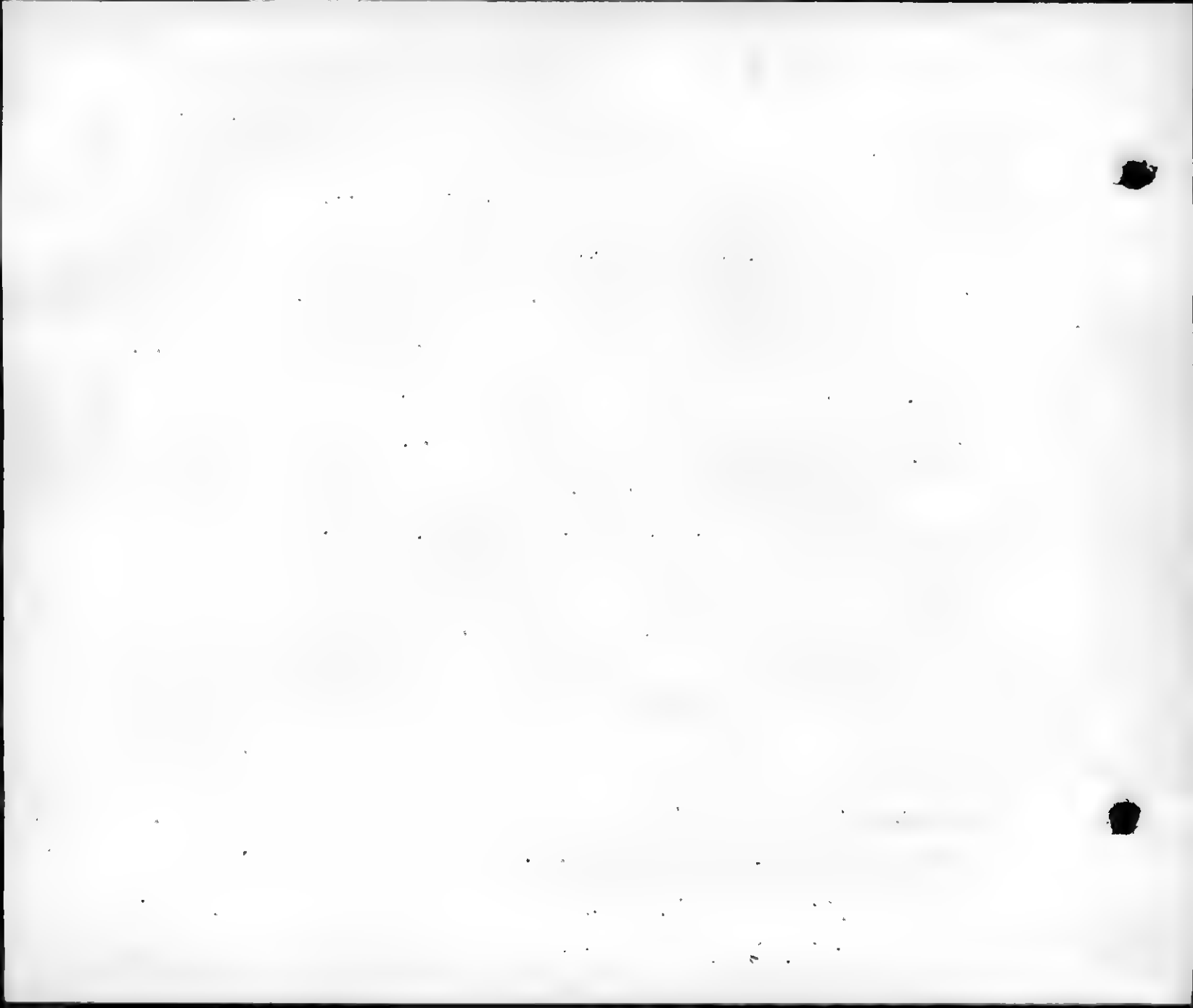
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>24 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institut on. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		e. STREET ADDRESS <b>2716 W. Fairmount Avenue</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First <b>Katie</b>		Middle <b>Sutton</b>		Last <b>Smith</b>		4. DATE OF DEATH Month <b>10</b> Day <b>30</b> Year <b>59</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 28, 1881</b>		9. AGE (In years last birthday) yrs. <b>78</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Sutton</b>		14. MOTHER'S MAIDEN NAME <b>Harriet</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unknown</b>		INFORMANT <b>Hospital Records</b>		Address		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> (c)		INTERVAL BETWEEN ONSET AND DEATH											
18. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome Associated with Senility</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		20c. TIME OF INJURY Month. Day. Year Hour a. m. ----- p. m. ----- <b>19</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) ----- (County) ----- (State) -----											
21. I certify that I attended the deceased from <b>10/6</b> , 19 <b>59</b> , to <b>10/30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/30</b> , 19 <b>59</b> and that death occurred at <b>11:50</b> M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>		DATE SIGNED <b>10/30/59</b>		ACTUAL SIGNATURE <b>Hildegard Heard Reissman</b>		PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md.</b>		DATE <b>10/30/59</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>10/4/59</b>		22b. DATE THEREOF <b>10/4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Graveyard</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Corbin</b>		ADDRESS <b>372 Calverton</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William H. Hinton</b>		25. MEDICAL CERTIFICATION		26. MEDICAL CERTIFICATION		27. MEDICAL CERTIFICATION		28. MEDICAL CERTIFICATION		29. MEDICAL CERTIFICATION		30. MEDICAL CERTIFICATION							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



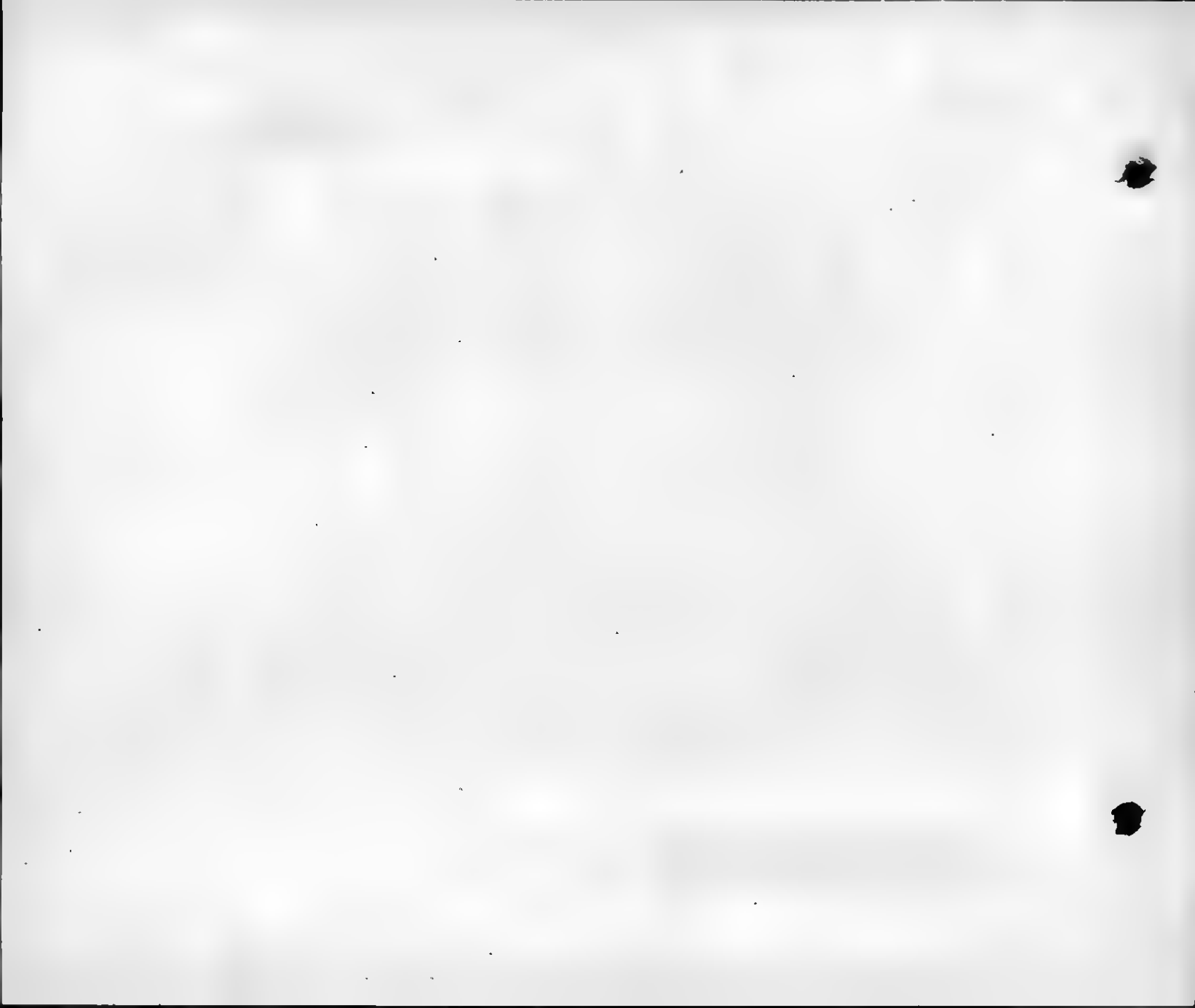
10996

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>James M. Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write nearest town) <i>Millersville Md</i>		c. CITY OR TOWN (If outside corporate limits, write nearest town) <i>Baltimore</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Amelia Sarah Straub</i>		4. DATE OF DEATH Month Day Year <i>Oct 30 - 19 59</i>	
5. SEX <i>F</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 8 1874</i> 9. AGE (In years last birthday) <i>85</i> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales lady</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>self-employed</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>	
13. FATHER'S NAME <i>Richard Mills</i>		14. MOTHER'S MAIDEN NAME <i>Mills</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <i>212-36-2751</i>	
17. INFORMANT <i>Carl W. Straub</i> Address <i>305 W. Furnace Branch Rd - Glen Burnie Md</i>		18. CAUSE OF DEATH (Enter only one cause primary for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Lobar Pneumonia</i> DUE TO (b) <i>Cerebral Thrombosis -</i> DUE TO (c) <i>Arteriosclerotic Vascular Disease</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>4 day</i>	
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <i>10/8/59</i> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>10/8/59</i> to <i>10/30-59</i> , that I last saw the deceased alive on <i>10/29/59</i> , and that death occurred at <i>3:15 A.M.</i> from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>Baltimore, Md</i> DATE SIGNED <i>10/30/59</i> ACTUAL SIGNATURE <i>Joseph Lipskey</i> M.D. PHYSICIAN NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/2/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Landon Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Goulson</i> ADDRESS <i>2359 Wash. Blvd. Balt. Md</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 2 59</i>	
24b. REGISTRAR'S SIGNATURE <i>Christine E. Fink</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10997

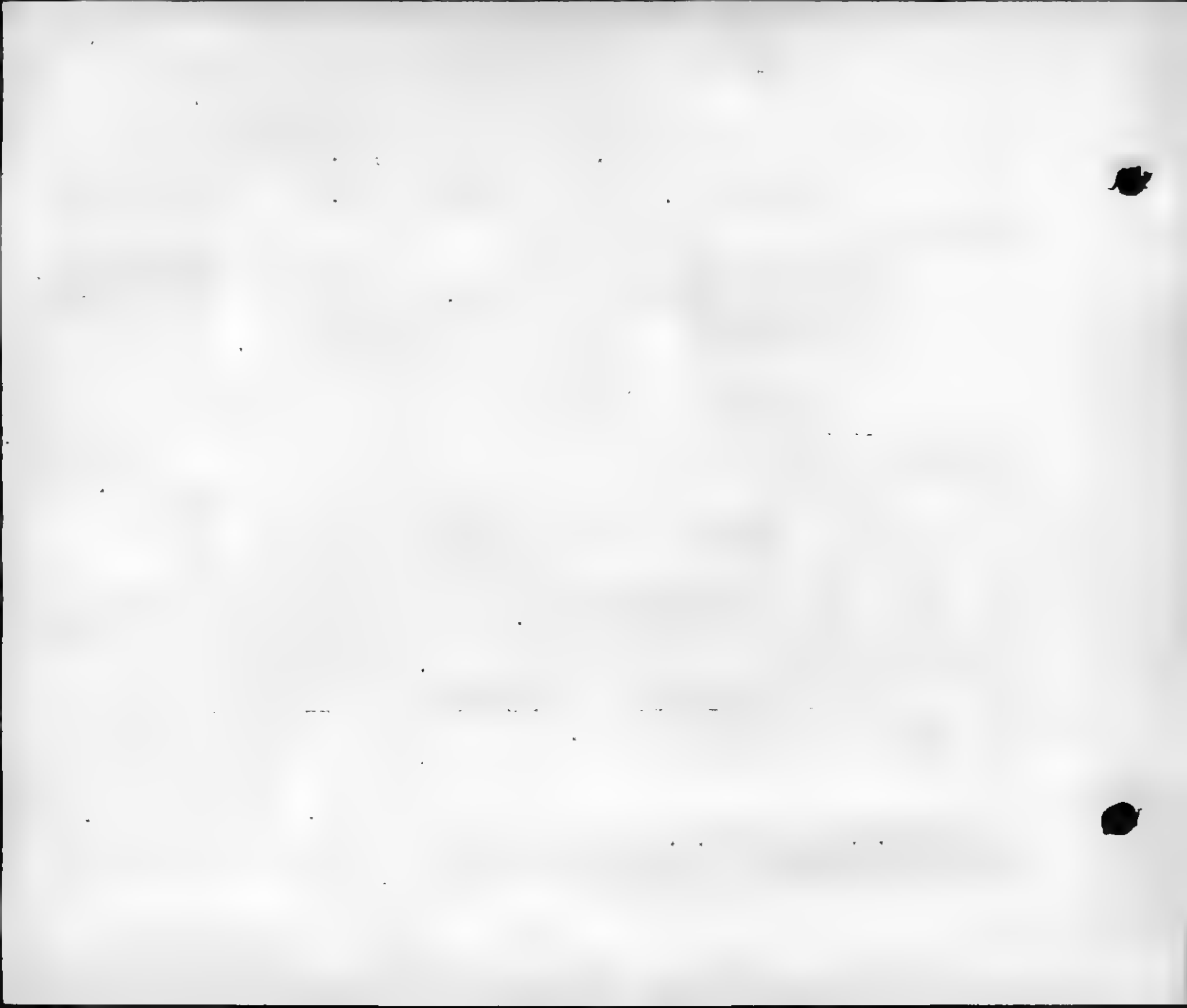
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admittance) o. STATE <b>Maryland</b> b. COUNTY <b>A. Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				c. LENGTH OF STAY IN 1b <b>1 mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11 Overhill Rd.</b>				d. STREET ADDRESS <b>829 West St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert Francis</b> Middle <b>SUITE</b> Last				4. DATE OF DEATH Month <b>October</b> Day <b>21</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 Aug. 1871</b>		9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR: Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min <b>---</b> IF UNDER 24 HRS. <b>---</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mortician (ret)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>same</b>		11. BIRTHPLACE (State or foreign country) <b>Anne Arundel Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>yes</b>	
13. FATHER'S NAME <b>Charles Montgomery Suite (dec)</b>				14. MOTHER'S MAIDEN NAME <b>Mary Virginia Scheckells (dec)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs Mary Mendez (daughter) 11 Overhill Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b>						<b>1 hr.</b>	
610x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertrophy of Prostate</b>						<b>2 yrs</b>	
DUE TO (c) <b>Growth on Epiglottis</b>						<b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General Senility, Slight Strokes.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>No accident or injury.</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>---</b> p. m. <b>---</b> <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	
20f. (City or town) <b>---</b>				20g. (County) <b>---</b>		20h. (State) <b>---</b>	
21. I certify that I attended the deceased from <b>7 Oct. 19 59</b> to <b>Present time</b> , that I last saw the deceased alive on <b>17 October 19 59</b> , and that death occurred at <b>10:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>901 Edgerly Rd., Glen Burnie, Md.</b> DATE SIGNED <b>21 October 1959</b>							
ACTUAL SIGNATURE <b>H.F. Manuzak</b> M.D.				PHYSICIAN'S NAME (Type) <b>H.F. Manuzak L.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 23-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cent</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Golem M. Layla Dms</b>				24a. REC'D BY REGISTRAR <b>DATE OCT 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10979

Reg. Dist. No.

10998

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Montgomery</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>30 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dayton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maryland Yacht Club, Rock Creek</u>				d. STREET ADDRESS <u>4241 Cleveland Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Steven H. Sunstie, Sr</u>				4. DATE OF DEATH <u>October 20th, 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1892</u>	9. AGE (In years last birthday) <u>67</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Restaurant operator.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ishphening, Michigan.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Steven H. Sunstie</u>			14. MOTHER'S MAIDEN NAME <u>unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes, Marine, World War #1</u>		16. SOCIAL SECURITY NO. <u>#1</u>		17. INFORMANT Address <u>Mr. Robert E. Derr (Brother in law)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>400.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO (a), stating the underlying cause last. (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) <u>  </u>	(County) <u>  </u>	(State) <u>  </u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/20/59</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 23., 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dayton Memorial Park</u>		22d. LOCATION (City, town, or county) <u>Dayton, Ohio</u>		(State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Davidson, Laurel Md</u>				24a. REC'D BY REGISTRAR <u>OCT 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. F. F. F.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

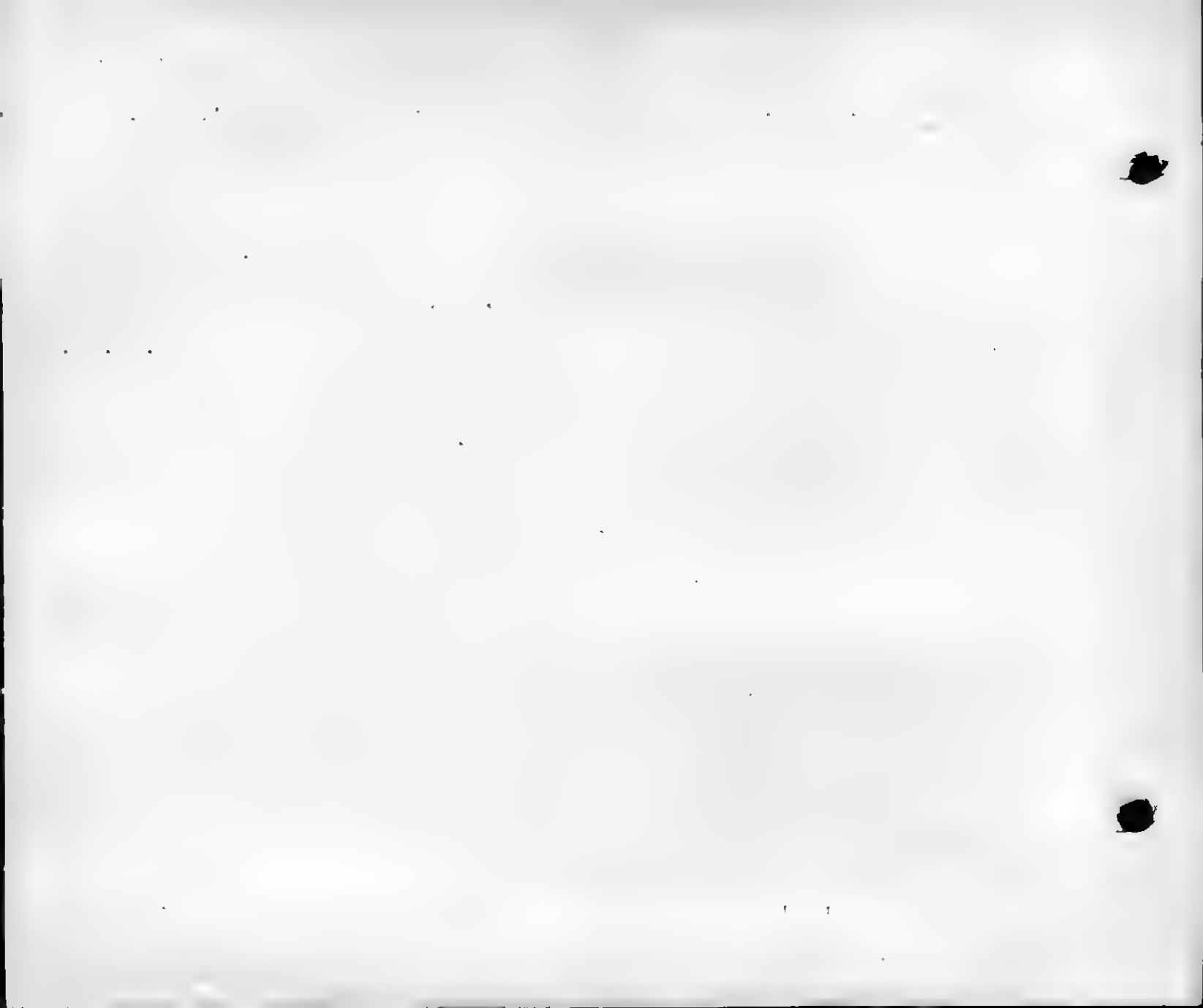
10999

## CERTIFICATE OF DEATH

Reg. Dist. No. 10980

1. PLACE OF DEATH a. COUNTY <b>A.A. Co.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>A.A. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harundale, Maryland</b>		c. LENGTH OF STAY IN 1b <b>X</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harundale, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1617 Kimber Road</b>		d. STREET ADDRESS <b>1617 Kimber Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LAURA</b> First <b>ISABELLE TAYLOR</b> Middle <b>TAYLOR</b> Last		4. DATE OF DEATH <b>October 11</b> Month <b>1959</b> Day <b>11</b> Year	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 19, 1866</b>
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>	IF UNDER 24 HRS Months <b></b> Days <b></b> Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Wray</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Orem</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b></b>	
17. INFORMANT <b>Sidney T. Taylor</b> Address <b>4136 Wilkens Avenue</b>		# <b>29</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertensive Cardiovascular</b> DUE TO (c) <b>Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 7, 1959</b> to <b>October 11, 1959</b> that I last saw the deceased alive on <b>October 10, 1959</b> , and that death occurred at <b>4:20 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmond J. Moushalek</b> M.D. <b>2101 Ritchie Highway</b>		DATE SIGNED <b>Oct 11, 1959</b>	
PHYSICIAN'S NAME (Type) <b>EDMOND J. MOUSHALEK</b>		<b>Glen Burnie</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/14/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Avenue</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



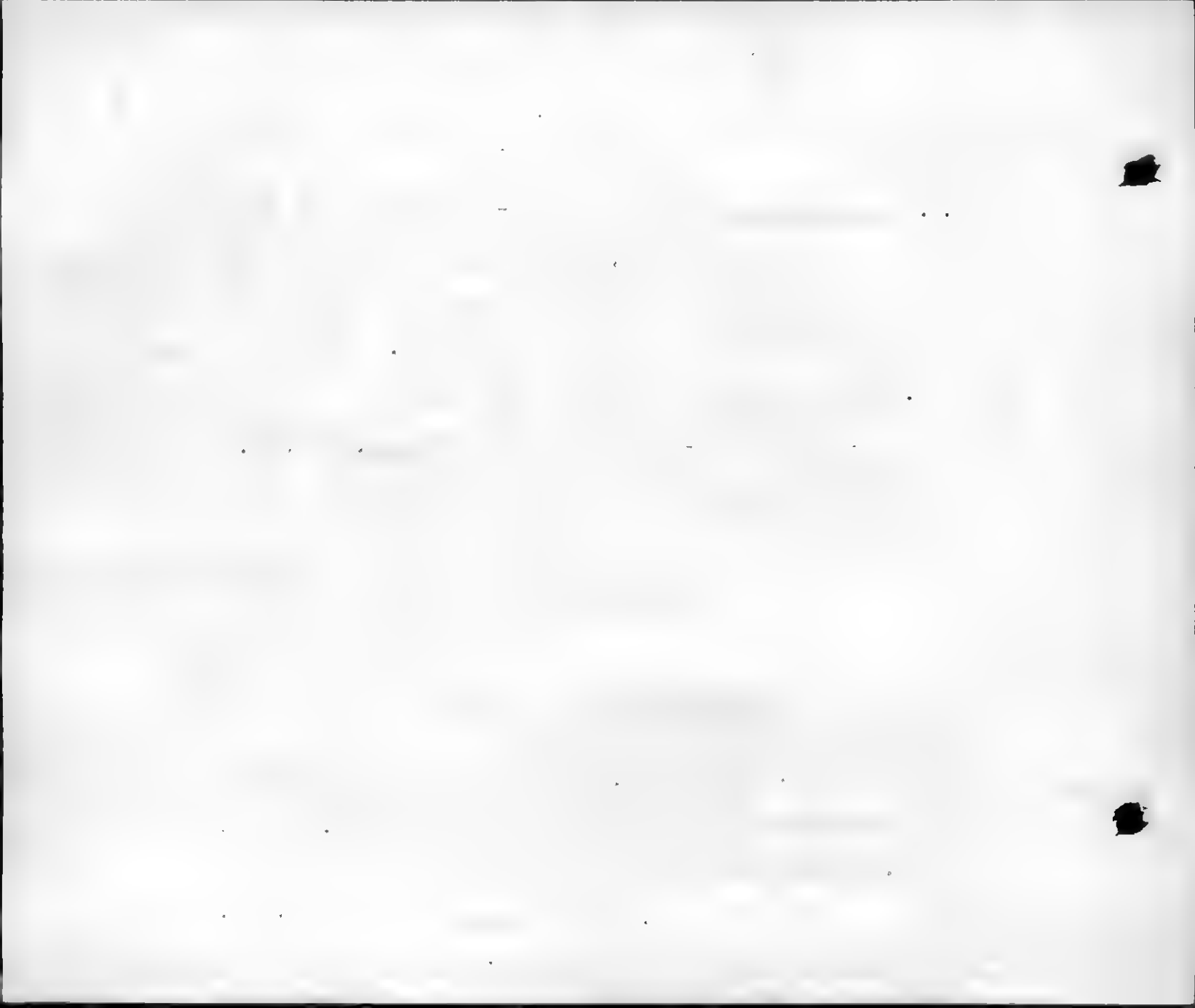
11000

## CERTIFICATE OF DEATH

Reg. Dist. No. 10981

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft Meade, USAH</u>		c. LENGTH OF STAY IN TB <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u>		e. STREET ADDRESS <u>Apt-7 Laurel Manor Court</u>	
3. NAME OF DECEASED (Type or print) First <u>Taylor (Infant Male)</u> , Middle <u>Steven</u> , Last <u>LeRoy</u>		4. DATE OF DEATH Month <u>October</u> , Day <u>18</u> , Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 Oct 1959</u>
9. AGE (in years last birthday) <u>— yrs</u>		10. IF UNDER 1 YEAR Months <u>5</u> , Days <u>—</u> , Hours <u>—</u> , Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>FGGM, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward L. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Rose Renda</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Personnel Records, FGGM, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____			
INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>18 October, 1959</u> , to <u>18 October, 1959</u> , that I last saw the deceased alive on <u>never saw pt. alive</u> , and that death occurred at <u>0210AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Richard A. Gilbert</u>		ADDRESS (Street, city or town, state) <u>M.D. 1726 Eys St. N.W. Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>C. Richard A. Gilbert</u>		DATE SIGNED <u>18 Oct 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Rose Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>York. Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley, Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Hana</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>OCT 21 '59</u>	

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11001

## CERTIFICATE OF DEATH

10982

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14. Pasadena, Md.</u>		c. LENGTH OF STAY IN 1b <u>16 Mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Benn's Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charlotte E. Thomas</u>		4. DATE OF DEATH <u>10/5/59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 Jan 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>5</u> Hours <u>59</u> Min.	IF UNDER 24 HRS Months <u>10</u> Days <u>5</u> Hours <u>59</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Emerson Hotel</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>(Unknown) Wolfe</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Melvin Thomas - North Shore, Pasadena, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO <u>Chronic Cystitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) <u>Bye</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralysis - Residual</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/24/59</u> to <u>10/5/59</u> , that I last saw the deceased alive on <u>10/3/59</u> , and that death occurred at <u>Md.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Lipskey</u>		ADDRESS (Street, city or town, state) <u>10/5/59</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH LIPSKEY</u>		DATE SIGNED <u>10/5/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9 Oct. 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ormid Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Pasadena, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Simbula</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11002

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>20 yrs. 5 mo. 3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mayfield</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>?</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>Thorne</b> Last <b>Thorne</b>				4. DATE OF DEATH Month <b>10</b> Day <b>3</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1911</b>		9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		INFORMANT Address <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis - Far Advanced</b> <b>002x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental Defective</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>-----</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. <b>9</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/30</b> 19 <b>59</b> , to <b>10/3</b> 19 <b>59</b> , that I last saw the deceased alive on <b>10/3</b> 19 <b>59</b> , and that death occurred at <b>10:50</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Crownsville State Hospital, Md. 10/5/59</b> ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M. D.</b> PHYSICIAN'S NAME (Type) <b>Crownsville State Hospital, Md. 10/5/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Remove</b>		22b. DATE THEREOF <b>10-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mayfield &amp; Sons</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Reese II</b>				24a. REC'D BY REGISTRAR <b>UCT 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kinn</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11003

## CERTIFICATE OF DEATH

10984

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Box 73, Niantic, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Manhattan Beach, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Greenacres, Crisp, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLIFFORD William Tompkins</u> First Middle Last		4. DATE OF DEATH <u>10-19-59</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19-1-1890</u> Month Day Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - General Bellman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Upper Wharton Co., Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Upper Wharton Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Robert R. Tompkins</u>		14. MOTHER'S MAIDEN NAME <u>Frederick F. Tompkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>500-1-10000</u>	
17. INFORMANT <u>John</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension C. V. Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-5-59</u> 19 <u>59</u> to <u>10-19-59</u> 19 <u>59</u> , that I last saw the deceased alive on <u>10-13-59</u> 19 <u>59</u> , and that death occurred at <u>130</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Robert R. Hahn, M.D.</u> <u>Robert R. Hahn</u> <u>10-19-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-2 Oct-1959</u>	<u>London Park Cem.</u>	<u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>OCT 23 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hahn</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10955

## CERTIFICATE OF DEATH

Reg. Dist. No.

10985

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A. 1092</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Round Bay Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood Convalescent</u>		e. STREET ADDRESS <u>14 Severn River Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Ida Wilson Vang</u>		4. DATE OF DEATH <u>Oct 28</u> 19 <u>59</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 23 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	
11. BIRTHPLACE (State or foreign country) <u>Madison, Tenn</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>John T. Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Jane Jopling</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Doughter Mrs. Auld</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastroenteritis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1956</u> , 19 <u>56</u> to <u>present</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-16-59</u> , 19 <u>59</u> and that death occurred at <u>2 PM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Robert R. Hahn</u>		ADDRESS (Street, city or town, state) <u>Severna Park Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>		DATE SIGNED <u>10-28-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John L. McHenry</u>		24. REC'D BY REGISTRAR <u>Oct 29 '59</u>	
ADDRESS <u>Baltimore, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11004

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crofton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crofton Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Richard D. Wallace</i>		4. DATE OF DEATH <i>10 24 19 59</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 17 1891</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Crofton Tenn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Wallace</i>		14. MOTHER'S MAIDEN NAME <i>Belle Wallace Shinliver</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>220-12-8613</i>	
17. INFORMANT <i>Ona Wallace - old sister-in-law</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis -</i> <i>420.1</i> DUE TO <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease -</i> DUE TO <i>—</i> (c) <i>Myocardial Infarction -</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 yr</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary Atherosclerosis</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>—</i> 19 <i>59</i> p. m. <i>—</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>
21. I certify that I attended the deceased from <i>4/21</i> , 19 <i>57</i> , to <i>10/24</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>8/20</i> , 19 <i>57</i> , and that death occurred at <i>7:30</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Felix Grunberg</i> M.D.		ADDRESS (Street, city or town, state) <i>P.O. Box 27 Crofton - Md.</i>	
PHYSICIAN'S NAME (Type) <i>Felix Grunberg</i>		DATE SIGNED <i>11/24/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct. 27, 59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Memorial</i>	22d. LOCATION (City, town, or county) (State) <i>Glen Burnie Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping &amp; Kirkley</i> ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR <i>—</i> DATE <i>OCT 28 1959</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kins</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22 Film 50 10-23-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

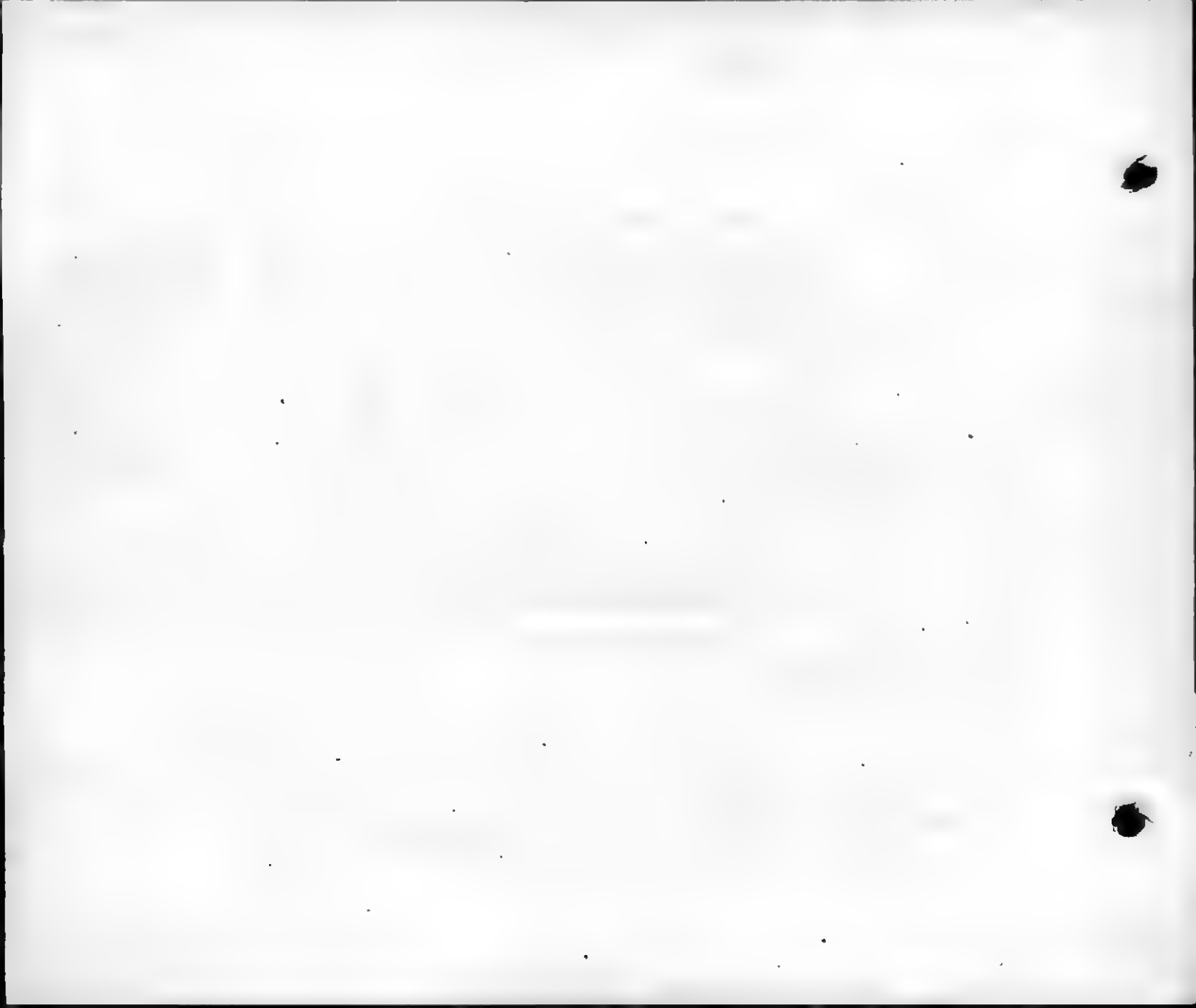
10987

10956

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Crownsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen. Hosp.</u>				1d. STREET ADDRESS <u>Eddye Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>May</u> Last <u>Ward</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 15 - 1894</u>		9. AGE (n years last birthday) <u>65</u> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Davidson</u>				14. MOTHER'S MAIDEN NAME <u>Sally Lawson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>—</u>		INFORMANT Address <u>Mrs Ruby Spence - Oakwood Rd. Gty Bowie</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BLIND PNEUMONIA</u> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL THROMBOSIS</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PARKINSON'S DISEASE (PARALYSIS AGITANS)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-8-1959</u> to <u>10-18-1959</u> , that I last saw the deceased alive on <u>10-18-1959</u> , and that death occurred at <u>3:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S Beck</u> M.D. <u>41 Southgate Ave</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>10-18-59</u>			
PHYSICIAN'S NAME (Type) <u>Annapolis, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 21-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Walters - Pratt &amp; Stricker Sts</u>				24a. REC'D BY REGISTRAR <u>OCT 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

Baltimore 23, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

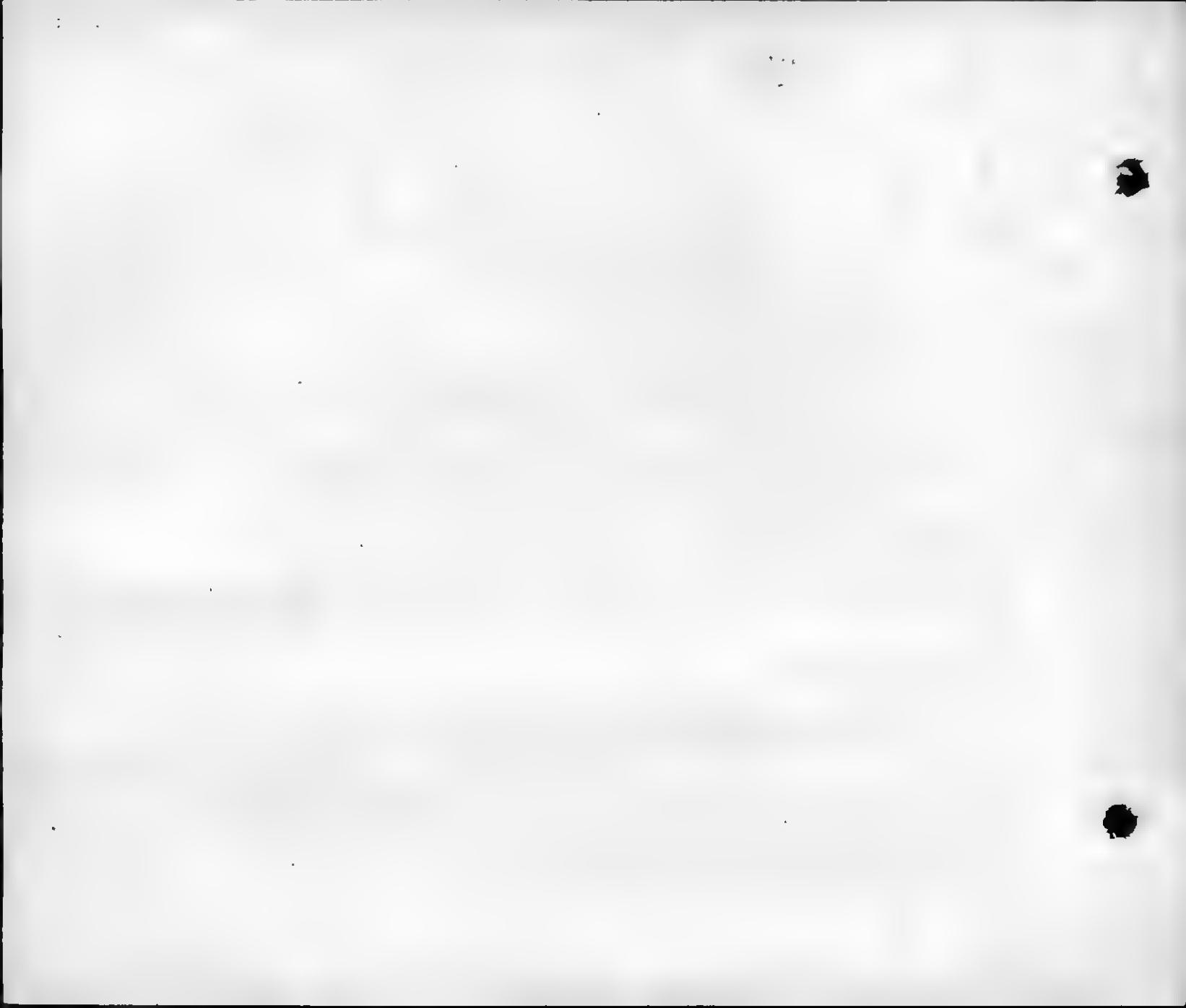
10988

11005

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPE ST. CLAIRE</u>		c. LENGTH OF STAY IN 1b <u></u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BROADVIEW DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>STANISLAWA (STELLA) WESOLOWSKI</u>		4. DATE OF DEATH <u>October 14 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Poland</u>	
13. FATHER'S NAME <u>Frank Lukowiak</u>		14. MOTHER'S MAIDEN NAME <u>Michalina Lukowiak</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Eva Adamski Broadview Drive A.A. Co. Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer descompensation and failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Senile arteriosclerotic nephrosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis and hypertension</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>3 years or more</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-7</u> , 1959, to <u>10-14</u> , 1959, that I last saw the deceased alive on <u>10-13</u> , 1959, and that death occurred at <u>3:15</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bertrand C.R. Gau</u>		ADDRESS (Street, city or town, state) <u>River Bay Road, Cape St. Claire, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Bertrand C.R. GAU</u>		DATE SIGNED <u>10/14/59</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/17/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Win. S. Fialkowski</u>		ADDRESS <u>2007 Eastern Ave</u>	
24a. REC'D BY REGISTRAR <u>OCT 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinnel</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11006

## CERTIFICATE OF DEATH

10989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>45 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>#106 "A" Street, S.W.</b>				d. STREET ADDRESS <b>#106 "A" Street, S.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SARAH</b>		First <b>A.</b>		Middle <b>WOODFALL</b>		Lost <b>19 59</b>	
4. DATE OF DEATH <b>OCTOBER 28</b>		Month <b>28</b>		Day <b>19 59</b>		Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/></b>	8. DATE OF BIRTH <b>16 Jan. 1881</b>	9. AGE (In years last birthday) <b>78</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Sec. (ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bld. &amp; Loan</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles W. Bloom</b>				14. MOTHER'S MAIDEN NAME <b>Mary Kelley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Mrs. Betty Brandenburg</b>		Address <b>Same As #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardio - Vascular Disease (10 years)</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 48</b> to <b>28 Oct.</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>27 October, 19 59</b> , and that death occurred at <b>4: A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James S. Billingslea</b>		M.D. <b>#108 Central Ave., N.W.</b>		DATE SIGNED <b>10/28/59</b>			
PHYSICIAN'S NAME (Type) <b>James S. Billingslea, M.D.</b>		<b>Glen Burnie, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>31 Oct. 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Brooklyn, RFD, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. V. Singleton</b>		ADDRESS <b>Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Orville S. Kline</b>	

CERTIFICATE OF DEATH

11006

Page 1

*[The following text is mirrored bleed-through from the reverse side of the document and is not legible.]*

NAME OF DECEASED: \_\_\_\_\_  
AGE: \_\_\_\_\_  
SEX: \_\_\_\_\_  
RACE: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
PLACE OF BIRTH: \_\_\_\_\_  
DATE OF DEATH: \_\_\_\_\_  
PLACE OF DEATH: \_\_\_\_\_  
CAUSE OF DEATH: \_\_\_\_\_  
MANNER OF DEATH: \_\_\_\_\_  
SIGNATURE OF PHYSICIAN: \_\_\_\_\_  
SIGNATURE OF REGISTRAR: \_\_\_\_\_  
DATE OF REGISTRATION: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10957

CERTIFICATE OF DEATH

10990

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Rox 189 Defence Highway</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>ZAKRZEWSKI</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 14, 1959</u>
9. AGE (In years last birthday) yrs. <u>13</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10. AGE (In years last birthday) yrs. <u>13</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Zakrzewski</u>		14. MOTHER'S MAIDEN NAME <u>Roxie D. Rogers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
INFORMANT <u>Mr Edward Zakrzewski- Father- same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complications, severe</u> <u>560.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/14, 1959</u> , to <u>10/14, 1959</u> , that I last saw the deceased alive on <u>10/14, 1959</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Robert A. Riley</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Robert A. Riley MD</u> <u>69 Franklin Street, Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 15, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 19 59</u>	
ADDRESS <u>Annapolis, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2063181XV2

County of \_\_\_\_\_

State of \_\_\_\_\_

Page \_\_\_\_\_

(1)



(1)

